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IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

HEALTHAMERICA and PAMELA MERLE,
Petitioners,
v.
EDWARD MENTON,
Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF ALABAMA

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QUESTIONS PRESENTED

(1) Whether the Employee Retirement Income Security Act ("ERISA") preempts state common law fraud claims, including unlimited punitive damages, which arise out of the process of explaining plan options and coverages to participants in an existing welfare benefit plan.

(2) Whether Alabama's "twisting statute" is a law which regulates the business of insurance under Section 514(b) of ERISA and is thus saved from preemption.

(3) Whether a punitive damages award must be proportionate to a Plaintiff's actual damages and to the character of a Defendant's alleged misconduct to avoid violation of a Defendant's rights to substantive due process under the Fourteenth Amendment.

(4) Whether the Alabama standard governing whether punitive damages may be awarded for civil fraud violates the due process clause of the Fourteenth Amendment.

(5) Whether the Alabama trial and appellate procedures allowing the jury ungoverned and unlimited discretion in awarding punitive damages for civil fraud violates the due process clause of the Fourteenth Amendment.

PARTIES TO THE PROCEEDING

Health America * and Pamela Merle
Edward Menton

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* Menton sued "Health America" and Pamela Merle. HealthAmerica and the Mobile Press Register, Inc. entered into a contract (Group Application) whereby HealthAmerica agreed to provide certain health care services and benefits in accordance with the provisions of a Group Subscription Agreement and Schedule of Benefits. According to the Group Subscription Agreement, HealthAmerica Alabama L. P., was the legal entity providing health care services and benefits. HealthAmerica Alabama L. P. was formed in December of 1983 to operate a health maintenance organization in Alabama. Its ultimate general partner is HealthAmerica G. P., Inc., which is a wholly owned subsidiary of HealthAmerica Corporation. Neither HealthAmerica G. P., Inc., nor HealthAmerica Corporation operate health maintenance organizations. In November of 1986, all of the outstanding stock of HealthAmerica Corporation was acquired by Maxicare Health Plans, Inc. In March of 1987, the name of HealthAmerica Alabama L. P., was changed to Maxicare Alabama, L. P. In August of 1987, Maxicare Southeast Health Plans, Inc., acquired the assets and liabilities, but not the partnership interest of Maxicare Alabama L. P., and continued to conduct Alabama operations. The following are companies that may be deemed affiliates or subsidiaries of Maxicare Southeast Health Plans, Inc., or HealthAmerica Corporation: Account Management Services, Inc.; American Medical Plan, Inc.; Bressco, Inc.; Family Health Services, Inc.; Fhills Partnership; General Med Investors, Ltd.; General Medical Centers, Inc.; HCS Computer, Inc.; HealthAmerica Frankford, Inc.; HealthAmerica G.P., Inc.; HealthAmerica Partners, L.P.; HealthAmerica Tennessee, Inc.; Healthcare Alternatives, Inc.; Healthcare Assurance Company, Ltd.; Healthcare Consultants, Inc.; Healthcare USA Inc.; Highland Medical General Partnership; Highland Medical Limited Partnership; Independence Health Plan, Inc.; Independence Health Plan of Southeastern Michigan, Inc.; Lomita-Torrance Building Joint Venture; Mauli-Ola, Inc.; Maxicare; Maxicare Alabama, L.P.; Maxicare Arizona, Inc.; Maxicare Arkansas, Inc.; Maxicare Computing, Inc.; Maxicare/HealthAmerica Florida, Inc.; Maxicare HealthAmerica Health Plan of Arizona, Inc.; Maxicare/HealthAmerica Nebraska, Limited Partnership; Maxicare Health Insurance Company; Maxicare Health Plan of Missouri, Inc.; Maxicare Health Plans, Inc.; Maxicare Health Plans of Kentucky, Inc.; Maxicare Health Plans of the Midwest, Inc.; Maxicare Holdings, Inc.; Maxicare Kentucky, Inc.;

Maxicare Life and Health Insurance Company; Maxicare Louisiana, Inc.; Maxicare Maryland, L.P.; Maxicare Midwest Health Plans, Inc.; Maxicare New Jersey, Inc.; Maxicare New York, Inc.; Maxicare North Carolina, Inc.; Maxicare North Texas, Inc.; Maxicare Pharmacies, Inc.; Maxicare/UHS Nevada, Inc.; Maxicare Utah, Inc.; Maxicare Virginia, L.P.; Maxicare Washington, Inc.; National Pharmaceutical Services, Inc.; Penn Health Corporation; RCP, Inc.; Tucson—Group Health Medical Associates, P.C.

Out of an over-abundance of caution, Petitioners are serving the Attorney General of Alabama with this petition, pursuant to 28 U.S.C. § 2403(b), even though they are not challenging the constitutionality of any statute; rather, they are challenging the award of punitive damages based on a claim of common law fraud.

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IN THE

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OCTOBER TERM, 1989

No.

HEALTHAMERICA and PAMELA MERLE,
Petitioners,

v.

EDWARD MENTON,
Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF ALABAMA

The Petitioners, HealthAmerica and Pamela Merle, respectfully pray that a writ of certiorari issue to review the judgment and opinion of the Supreme Court of Alabama entered in this proceeding on July 21, 1989.

OPINIONS BELOW

The opinion of the Supreme Court of Alabama is reported at 23 ABR 3436 (1989) (Ala. Bar Rep.), and appears in App. A, 1a-44a. The Circuit Court of Mobile County, Alabama, issued no opinion.

JURISDICTIONAL STATEMENT

The opinion and judgment of the Supreme Court of Alabama, affirming the $1,800,000.00 judgment against Petitioners, was entered on July 21, 1989. Petitioners filed a timely Application for Rehearing on August 4, 1989, which was denied on September 15, 1989 and no further opinion was issued. App. B, 45a-46a. This petition for

writ of certiorari is being filed within ninety (90) days from the denial of Petitioners' Application for Rehearing in the Supreme Court of Alabama. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(a).

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

This case involves sections 2, 101, 102, 104, 401, 404, 409, 502, and section 514 of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. §§ 1001, 1021(a), 1022, 1024(b), 1101, 1104, 1109, 1132, and 1144(a) & (b); the McCarran-Ferguson Act, 15 U.S.C. § 1012 (1988); the Fourteenth Amendment of the United States Constitution; and *Ala. Code*, § 27-12-6 (1975). The relevant portions of these provisions are reproduced at App. D, 50a-63a.

STATEMENT OF THE CASE

A. Material Facts

Prior to 1985, Respondent's employer, the Mobile Press Register, Inc. ("MPR"), established an employee welfare benefit plan. The MPR solicited proposals from different insurers as a routine matter each year for possible inclusion in its welfare benefit plan, in order to provide "the best benefit package for our employees." In the spring of 1985, the MPR entered into negotiations with two health maintenance organizations (Prime Health and Respondent HealthAmerica) for the purpose of possibly including these HMOs as alternatives to the traditional insurance option within its benefit plan. On May 15, 1985, the MPR entered into a written contract with HealthAmerica whereby HealthAmerica agreed to provide certain health care benefits to eligible members of the MPR group and their dependents.

It is undisputed that Respondent was a participant in the MPR's welfare benefit plan prior to July 1, 1985,

under the traditional health insurance policy, was a participant in the MPR's plan after July 1, 1985, and remains an employee and participant in the MPR's plan. Under the traditional health insurance option in which Respondent was enrolled prior to July 1, 1985, Connecticut General paid 80% of the cost of physical therapy and medical appliances, such as crutches, braces, and walkers.

The Assistant General Manager at the MPR, David Parker, solicited information from insurers and HealthAmerica, negotiated with HealthAmerica, and signed the May 15 agreement between HealthAmerica and the MPR. Parker sent a letter and a packet of information from his office to MPR employees, including Respondent. Parker's May 23, 1985 letter to MPR employees states, "Management will soon offer employees, as an alternative medical benefit selection, the two health maintenance organizations (HMOs) in our area. . . ." Parker also prepared and distributed a two page "summary of benefits."

Although Respondent received this literature from the MPR, he could not determine whether physical therapy, crutches, and braces would be covered under the new HMO options. Respondent was concerned about these benefits because his son suffered certain medical problems which would require surgery followed by physical therapy. Respondent was interested in a program that would pay more than the 80% paid under the traditional insurance option. Respondent went to see Parker with his question, and Parker suggested that Respondent should go to one of the scheduled informational meetings and ask the representatives of the two new plan options. Parker testified that he avoided answering questions about coverage: "I try and avoid putting myself in the position of answering specific questions about coverage just to avoid any liability on the company's part as to making a representation of coverage."

Respondent attended a June 17, 1985 meeting at the MPR during which Petitioner Pamela Merle (a Health-

America employee) explained the HealthAmerica option, a representative from Prime Health explained its option, and Parker explained the traditional Connecticut General insurance. At the end of the meeting, Respondent approached the HMO representatives and informed them of his son's need of surgery and subsequent rehabilitation. He said, "and I asked how they covered or would it be covered or something like that." Respondent testified, "I was told it would be covered a hundred percent by HealthAmerica."

The HealthAmerica schedule of benefits does cover physical therapy or rehabilitation at one hundred percent, but only for the first two months of treatment. There is no evidence that Ms. Merle was aware of the limitation on physical therapy or rehabilitation benefits when she answered Respondent's question at the meeting.

Immediately after the meeting, Parker, who was present when Respondent asked his question, told Respondent, "You're not going to lose anything if you go that way," meaning HealthAmerica.

On June 24, 1985, Respondent enrolled himself and his family under the HealthAmerica option, with an effective date of July 1, 1985. He testified that he did not receive a copy of the actual Schedule of Benefits under the HealthAmerica program until *after* he had enrolled. Although he received the Schedule before his son commenced therapy on July 30, 1985, he was concerned because the Schedule clearly indicated that physical therapy or rehabilitation services were covered for only two months from the beginning of such treatment. Respondent again consulted Parker and told him, "It looks like this particular coverage on rehabilitation is limited or excluded." Parker suggested Respondent call Ms. Merle at HealthAmerica.

Respondent called Ms. Merle. He told Merle he had received the Schedule of Benefits and it indicated that

coverage was limited, and, "She said she wasn't sure about that, she would check on it and call me back." Merle called him back and confirmed that he was reading the schedule correctly. Respondent then went to Parker and got him involved with handling the problem. There were several telephone communications between Respondent, Parker, and HealthAmerica, attempting to resolve the situation, and Parker wrote a letter to HealthAmerica. By letter of November 11, 1985, HealthAmerica said it would extend rehabilitation benefits for an additional sixty days. Ultimately, HealthAmerica paid for Respondent's son's physical therapy for only the first sixty days, through September 30, 1985, and did not extend benefits for the additional sixty days. Respondent's actual or out-of-pocket damages equal $2,412.00. App. at 24a.

The Group Subscription Agreement provides for the filing of written proof of a claim for benefits and, if such a claim is denied by HealthAmerica, the Agreement also provides for a formal grievance procedure, which includes an appeal to HealthAmerica's Board of Governors. While Respondent did attempt an informal resolution of his problem, it does not appear from the record that he exhausted these administrative procedures. Instead, Respondent filed a one count claim for common law fraud. The complaint was not predicated on *any* Alabama statutory provision.

B. Presentation of Federal Issues

Over a month before trial, Petitioners filed a motion for summary judgment and motion to strike Respondent's jury demand, supported by a brief, pursuant to the Employee Retirement Income Security Act of 1974 (ERISA). Petitioners' motions were denied on January 8 and 11, 1988, respectively. The day before trial, Petitioners filed a supplemental memorandum of law in support of their ERISA motions.

At the close of the Plaintiff's case, Petitioners moved for a directed verdict based upon ERISA preemption, *inter alia*. When the motion was argued, the trial court, *ex mero motu*, asserted that Alabama's "twisting" statute, *Ala. Code* § 27-12-6 (1975), and HMO statute, *Ala. Code* § 27-21a-1 (1975), might "save" Respondent's fraud claim from ERISA preemption. Despite Petitioners' objections that they were not sued for violation of those statutes and that neither statute provides a private cause of action, the trial court denied the Petitioners' motion and submitted the case to the jury on Respondent's common law fraud claim.

The jury returned a verdict for Respondent in the amount of $1,800,000.00. Final judgment was entered on January 14, 1988. Respondent subsequently filed an Amended Complaint alleging a violation of Alabama's twisting statute.

Petitioners filed a timely motion for JNOV or, in the alternative, for new trial or remittitur, which included challenges to the constitutionality of the punitive damages award. The trial court entered a written order denying Petitioners' motions and holding that Petitioners' federal constitutional issues were timely raised:

> [T]he Court has considered Defendants' claims that the imposition of punitive damages, both generally under Alabama law and specifically in the amount and as returned by the jury under the facts of this case, is unconstitutional under the Alabama as well as the United States Constitutions (particularly, the Due Process Clause of the 5th Amendment; the Due Process, Equal Protection, and Privileges and Immunities Clauses of the 14th Amendment; the Excessive Fines Clause of the 8th Amendment; the Contracts Clause and prohibition of Ex Post Facto laws of Article I, Section 10, Clause 1). Although these arguments were timely raised and effectively presented, the Court is unpersuaded by such arguments and therefore holds that the imposition of punitive

> damages, both generally under Alabama law and specifically in the amount as returned by the jury under the facts of this case, is constitutional under both the state and federal constitutions.

App. at 48a.

On appeal, a majority of the Alabama Supreme Court affirmed the judgment of the trial court, including the damages award. The majority adopted an alternative standard on the issue of ERISA preemption which finds no support in the decisions of this Court: A state law is not preempted unless it "purports" to regulate, directly or indirectly, "the terms and conditions of a plan." This alternative approach to ERISA preemption directly contravenes the intent of Congress in enacting the broadest express preemption clause in federal law. The Alabama court reached its opinion notwithstanding that: (a) ERISA and its legislative history demonstrates that Congress intended federal standards to be the exclusive source of law governing ERISA plans; (b) the imposition of inconsistent state law remedies in the administration of ERISA plans impedes interstate commerce and deters employers, insurers, and health care providers, from offering new benefits and options to participants; (c) Congress has specifically mandated the disclosure of information regarding plan benefits and coverages to participants and provided remedies for violation of said provisions and the allowance of state common law fraud actions interferes with this congressional plan and civil enforcement scheme; (d) the award of punitive damages under state fraud actions directly supplants the exclusive ERISA enforcement scheme and subject plans to ungovernable and inconsistent state standards.

REASONS FOR GRANTING THE WRIT

I. The Preemption Standard Adopted By The Alabama Court Was Rejected By Congress

Prior to the enactment of ERISA, Congress was dissatisfied with attempts at pension plan regulation which left many aspects subject to a conflicting system of state and federal regulation. H. R. Rep. No. 533, 93d Cong., 1st Session 2-5 (1973), *reprinted in* 1974 U.S. Code Cong. & Admin. News 4639, 4640-43 [hereinafter *Report* 533].[1] In enacting ERISA, Congress sought to protect interstate commerce and the interests of participants in employee benefit plans by creating a comprehensive federal regulatory scheme which would require the disclosure and reporting of information to participants, establish uniform standards of conduct and fiduciary obligations, and would provide certain specified remedies. ERISA Section 2, 29 U.S.C. § 1001 (1982). To insure that this framework would be preeminent, eliminating the threat of conflicting and inconsistent state regulation, Congress expressly preempted, with narrow exceptions, all state laws which "relate to any employee benefit plan." ERISA Section 514 (a), 29 U.S.C. § 1144(a) (1982).

ERISA's sponsors emphasized that the bill was intended to foreclose non-federal regulation of employee benefit plans and to eliminate the threat of conflicting and inconsistent state laws. 120 Cong. Rec. 29197 (1974) (remarks of Rep. Dent); 120 Cong. Rec. 29933 (1974) (remarks of Sen. Williams); 120 Cong. Rec. 29942 (1974) (remarks of Sen. Javits). As the Court recognized in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983), the original House and Senate versions would have limited

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[1] For a general discussion of plan regulation prior to ERISA, see, Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, 48 U. Pitt. L. Rev. 427 (1987); and Note, *Defining the Contours of ERISA Preemption of State Insurance Regulation: Making Employee Benefit Plan Regulation an Exclusively Federal Concern*, 42 Vand. L. Rev. 607 (1989).

ERISA preemption to state laws dealing with matters expressly covered by ERISA's provisions—reporting, fiduciary responsibility, etc.—but the Joint Conference committee rejected these narrow provisions "in favor of the present language, and indicated that the Section's preemptive scope was as broad as its language." The preemption standard adopted by the majority of the Alabama court narrows the scope of preemption to only state law which "purports to regulate, directly or indirectly, the terms and conditions of a plan." This narrow standard is entirely inconsistent with the extremely broad express preemption provision enacted by Congress after considering and rejecting narrower versions.

Of course, if Congress determines that a particular species of state law should be excluded from the broad sweep of Section 514(a), it can easily do so by enacting additional narrow exceptions to preemption.[2] Additionally, Congress intended that the federal courts would develop a body of federal common law of ERISA to deal with issues involving rights and obligations under ERISA regulated welfare and pension plans. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. ——, 103 L.Ed. 2d 80, 92 (1989); *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1, 24 n. 26 (1983).

The preemption standard advanced by the Alabama court ignores the legislative history of § 514(a) and the intent of Congress that the administration of benefit plans would be governed by uniform federal standards.

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[2] *See, e.g.*, Pub. L. No. 97-473, § 301(a), 96 Stat. 2611, 2613 (1983) (codified at 29 U.S.C. § 1144(b)(5)(A) (1982) (Hawaii Prepaid Health Care Act); Pub. L. No. 98-397, 98 Stat. 1436 (1984) (codified at 29 U.S.C. § 1144(b)(7) (Supp. V 1988) (qualif. domestic relations orders).

II. The Decision Of The Alabama Court Is In Direct Conflict With The Decisions Of This Court And Other Federal Appellate Courts On The Scope Of Federal Preemption Under Section 514(a)

The decision of the Alabama court has resulted in the anomalous situation that a state law fraud claim in an Alabama court is not preempted while the identical claim in a federal district court in Alabama is preempted. This intolerable violation of the supremacy clause, U.S. Const. Article VI, must be resolved. The decisions of this Court, the Fifth, Ninth, and Eleventh Circuits all hold that a claim such as Respondent's is within the scope of Section 514(a) because it is concerned with and arises out of the administration of an ongoing ERISA benefit plan. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Farlow v. Union Central Life Ins. Co.*, 874 F.2d 791 (11th Cir. 1989); *Davidian v. Southern California Meat Cutters Union & Food Employees Benefit Fund*, 859 F.2d 134 (9th Cir. 1988); *Herman Hospital v. MEBA Medical & Benefits Plan*, 845 F.2d 1286 (5th Cir. 1988); *Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir. 1987); *Phillips v. Amoco Oil Co.*, 799 F.2d 1464 (11th Cir.), *cert. denied*, 481 U.S. 1016 (1987).

In *Shaw v. Delta Air Lines, Inc.*, the Court recognized that Congress used the words "relate to" in Section 514(a) in their broad sense and that the Courts must give effect to the intent of Congress and the plain language of the preemption clause. In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 43 (1987), the Plaintiff brought state law claims for "Tortious Breach of Contract," "Breach of Fiduciary Duties," and "*Fraud in the Inducement*" against the insurer providing benefits under the plan. After reviewing the legislative history of Section 514(a) and reaffirming that, "the express preemption provisions of ERISA are deliberately expansive, and designed to 'establish pension plan regulation as exclusively a federal concern,'" *id.* at 46, the Court stated that all three of the Plaintiff's common law claims related to the benefit

plan: "There is no dispute that the common law causes of action asserted in Dedeaux's complaint 'relate to' an employee benefit plan and therefore fall under ERISA's express pre-emption clause, § 514(a)." *Id.* at 47.

In *Farlow v. Union Central Life Ins. Co.*, 874 F.2d 791 (11th Cir. 1989), the Eleventh Circuit held that Alabama state law claims of fraudulent misrepresentation and negligence arising out of representations made to induce the Plaintiffs to purchase a new or different health plan related to the ERISA plan and were preempted. In determining whether a cause of action "relates to" an employee benefit plan, the Eleventh Circuit looked to whether the conduct giving rise to such claim was not "wholly remote in content" from the benefit plan. *Id.* at 794. In the present case, Respondent brought his fraud action when he failed to receive physical therapy and rehabilitation benefits beyond the sixty days specified in the Health-America schedule of benefits. Respondent's claims are based on certain representations which were made to him during the process, established by his employer, of explaining the coverages and benefits available under the three options within his employer's welfare benefit plan. Clearly, Respondent's claim would be preempted under the *Farlow* standard.

Similarly, in *Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir. 1987), the Plaintiffs claimed in their Amended Complaint that they were induced into purchasing certain coverage under an ERISA plan and, in reliance upon representations regarding coverage under that plan, into discontinuing their coverage under another existing policy of insurance. The Eleventh Circuit held that such Alabama fraud claims "relate to" the plan and are preempted. A certified copy of the Amended Complaint in *Belasco* was submitted to the Alabama Supreme Court following oral argument in this case.

The decision of the Alabama court is also in direct conflict with *Davidian v. Southern California Meat Cutters*

Union & Employees Benefit Fund, 859 F.2d 134 (9th Cir. 1988). In *Davidian*, the Plaintiff elected to switch or change options within his employer's welfare benefit plan as a result of certain representations made to him concerning the merits of the various available options. The Ninth Circuit held that the Plaintiff's fraud and deceit claims "related to" the plan and were preempted.[3]

In reaching its decision, the majority of the Alabama court relied on several inapplicable federal district court decisions which involved suits against employers for wrongful breach of the employment contract, for representations which induced the Plaintiff to accept employment, and for representations made by the employer during the ordinary course of business and not as part of the administration of a benefit plan. None of these cases can be properly applied to the facts of this case where the representation providing the basis for Respondent's suit occurred during the process of explaining coverages and options under an existing welfare benefit plan.

The majority opinion also relied on *Perry v. P*I*E* Nationwide, Inc.*, 872 F.2d 157 (6th Cir. 1989). *Perry* is factually distinguishable from the present case as the misrepresentation in *Perry* arose out of the sale of the corporation which employed the Plaintiffs and concerned the continuation or termination of employment if the Plaintiffs did not take certain action concerning a stock investment plan. The representations of the employer

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[3] Numerous other decisions recognize that a fraud or fraud in the inducement claim "relates to" the administration of the benefit plan and is preempted: *Herman Hospital v. MEBA Medical & Benefits Plan*; *Johnson v. District Two Marine Engineering Beneficial Association*, 857 F.2d 514 (9th Cir. 1988); *Straub v. Western Union Telegraph Co.*, 851 F.2d 1262 (10th Cir. 1988); *Reilly v. Blue Cross & Blue Shield of Wisconsin*, 846 F.2d 416 (7th Cir. 1988); *Phillips v. Amoco Oil Co.*, 799 F.2d 1464 (11th Cir. 1986); *Tucker v. Employers Life Ins. Co.*, 689 F. Supp. 1073 (N.D. Ala. 1988); *Comprehensive Care Corp. v. Doughtry*, 682 F. Supp. 516 (S.D. Fla. 1988).

were made by the employer in its capacity as employer rather than by any entity providing benefits as part of an employee welfare benefit plan, and the misrepresentation did not occur during either the employer's or provider's conduct in administering a benefit plan. In the instant matter the representation occurred during the administration of an existing welfare benefit plan and the explanation of options available under that plan. This Court should accept this petition and take this opportunity to insure that factually distinguishable cases are not used to narrow improperly the scope of ERISA preemption.

To the extent that *Perry* could be applied to the facts of this case, it is in conflict with the weight of federal authority. It is abundantly clear from *Pilot Life*, *Farlow*, *Belasco*, and *Davidian* that Congress did intend to preempt state laws regulating fraud or representations which occur during or arise out of the administration of an ERISA governed welfare benefit plan. The explanation of plan benefits and options within a plan is obviously part of the administration of the plan and, in fact, the disclosure of information to participants is specifically regulated by Congress. Thus, Respondent's claims "relate to" the benefit plan and are preempted because they arise out of the administration of the plan and the conduct giving rise to his claims is not "wholly remote in content" from the benefit plan.

III. Congress Specifically Regulated Information Disclosure And Fiduciary Standards Applicable To The Administration Of Welfare Plans, And The Application Of State Remedies In This Area Would Interfere With ERISA's Exclusive Enforcement Scheme

A. *Congress Specifically Regulated The Disclosure Of Information About Plan Benefits*

In the Court below, Respondent insinuated that he is left without a remedy if his state claim is preempted. However, Congress provided for the disclosure of benefit

information to plan participants and provided remedies if these disclosure requirements are not met.

One of the primary purposes of Congress in enacting ERISA was to insure that plan participants would receive accurate and full information about the benefits available under a plan. *Rodriguez v. Meba Pension Trust*, 872 F.2d 69, 74 (4th Cir.) *cert. denied*, 110 S.Ct. 202 (1989); *Edwards v. State Farm Mutual Auto Ins. Co.*, 851 F.2d 134 (6th Cir. 1988); ERISA Section 2, 29 U.S.C. § 1001 (a) and (b); *Report* 533, at 7-11, 18-20, *reprinted in* 1974 U.S. Cong. & Adm. News 4645-50, 4656-58; 120 Cong. Rec. 29928, 29931-32 (1974) (remarks of Sen. Williams). Specifically, Congress provided that a sufficiently accurate and comprehensive summary plan description should be furnished to all participants. ERISA Section 101, 29 U.S.C. § 1021(a) (1982); ERISA Section 102, 29 U.S.C. § 1022(a)(1) (1982); ERISA Section 104, 29 U.S.C. § 1024(b) (1982). Plan administrators are also required to make copies of the plan description available for examination by any plan participant in the principal office of the administrator and, upon written request of a participant, to furnish a copy of the latest updated summary plan description. ERISA Section 104, 29 U.S.C. § 1024(b)(2) & (4). Congress even provided criminal penalties for willful violation of the disclosure and reporting requirements of the act. ERISA Section 501, 29 U.S.C. § 1131 (1982).

An ERISA plan "administrator" has a statutory duty of disclosure and reporting. *Moran v. Aetna Life Ins. Co.*, 872 F.2d 296 (9th Cir. 1989); 29 U.S.C. § 1021(a) (1982). Because neither the Group Subscription Agreement nor Schedule of Benefits designates HealthAmerica as the administrator, the MPR as the "plan sponsor" is the administrator. *Moran v. Aetna*; *Davis v. Liberty Mutual Ins. Co.*, 871 F.2d 1134 (D.C. Cir. 1989).

Mr. Parker, acting on behalf of the MPR, solicited and received information from the two new HMO op-

tions. Parker prepared a two page comparative summary of benefits available under the three options which he sent to MPR employees before the June 17, 1985 meeting and before the June 30, 1985 option election date. After receiving information from Parker, including the summary, Respondent went to Parker with his question about coverage under the HealthAmerica option and, instead of either making a copy of the complete schedule of benefits available for Respondent to review in his office or obtaining a schedule for Respondent to review, Parker merely instructed him to attend the informational meetings being held at the MPR.

The MPR may have failed to provide Respondent with a "sufficiently accurate and comprehensive" description of the HealthAmerica option within its welfare benefit plan as required under 29 U.S.C. §§ 1021(a), 1024(b)(1) (1982). The MPR may have failed to make a copy of the HealthAmerica option available for examination by plan participants prior to the option election date, which may be a violation of 29 U.S.C. § 1024(b)(2) (1982). Section 1024(b)(1) imposes a duty on the administrator to furnish a plan description, without requiring a written request, and the failure to supply such information or the distribution of inaccurate or incomplete summary plan description provides the basis for an action under ERISA's civil enforcement scheme. *Davis v. Liberty Mutual*; *Rodriguez v. Meba Pension Trust*. An inaccurate or incomplete summary plan description provided by the administrator, upon which the participant relies, provides the basis for an action for benefits under ERISA. *Edwards v. State Farm*; *McKnight v. Southern Life & Health Ins. Co.*, 758 F.2d 1566 (11th Cir. 1985); *Genter v. ACME Scale & Supply Co.*, 776 F.2d 1180 (3rd Cir. 1985); *Kochendorfer v. Rockdale Sash & Trim Co., Inc.*, 653 F. Supp. 612 (E.D. Ill. 1987). Also, if Respondent made a written request to Parker for a complete schedule of benefits and Parker failed to comply before the option election date, July 1, 1985, the MPR would have violated

29 U.S.C. § 1024(b)(4) (1982) for which there would be an additional action under ERISA's enforcement scheme.

In conclusion, Congress specifically regulated the disclosure of information to plan participants so as to enable them to make informed choices regarding plans and options therein, and Respondent may have an action under ERISA's civil enforcement scheme for violation of these provisions. Since Congress has specifically regulated this aspect of the administration of welfare benefit plans and provided remedies for enforcement, the intrusion of state law and remedies into this area is beyond question preempted by Section 514(a). This case should have been remanded to the trial court for a determination of Respondent's rights under 29 U.S.C. § 1132(a) (1982).

B. *Congress Specifically Imposed Fiduciary Standards And Remedies Governing The Conduct Of Health-America As A Plan Fiduciary*

According to the documents governing the Health-America option within the MPR's benefit plan, the Schedule of Benefits and Group Subscription Agreement, HealthAmerica had the responsibility for determining claims for benefits and coverage under the HealthAmerica option. Accordingly, HealthAmerica is an ERISA fiduciary. *Pierre v. Connecticut General Life Ins. Co.*, 866 F.2d 141 (5th Cir. 1989); *Smart v. State Farm Ins. Co.*, 868 F.2d 929 (7th Cir. 1989); *America Federation of Unions Local 102 v. Equitable Life Assurance Society*, 841 F.2d 658 (5th Cir. 1988); ERISA Section 3(21), 29 U.S.C. § 1002(21)(A). "ERISA imposes a prudent man's standard of care upon anyone acting as a fiduciary with respect to an employee benefit plan as defined in the Act." *American Federation of Unions Local 102*, 841 F.2d at 662. Any fiduciary who violates 29 U.S.C. § 1104(a)'s duty to act in the best interest of participants is subject to liability under 29 U.S.C. § 1109(a). *Id.* Pamela Merle

was still in the process of being trained as a representative for HealthAmerica and her answer of Respondent's specific coverage question, obviously given without knowledge of the sixty day limit on rehabilitation benefits, may have constituted a breach of fiduciary duty under ERISA. *Berlin v. Michigan Bell Tel. Co.*, 858 F.2d 1154, 1163 (6th Cir. 1988); *Local Union 2134, UMW v. Powhatan Fuel*, 828 F.2d 710 (11th Cir. 1987).

Additionally, Respondent testified that Ron Scott, a manager at HealthAmerica, called Mr. Parker and told him to tell Respondent not to fill out the formal "grievance forms" sent to him by HealthAmerica because "we're going to take care of this." If this conversation actually occurred and if Respondent failed to pursue his formal grievance or appeal procedures because of this, HealthAmerica could be liable for additional breach of fiduciary duties under ERISA's enforcement scheme. Congress intended that the internal dispute resolution procedures required by the act should be followed, in part, because the exhaustion of such formal procedures creates a fully developed factual record which assists courts in reviewing the actions of fiduciaries. *Makar v. Health Care Corp. of the Mid-Atlantic*, 872 F.2d 80 (4th Cir. 1989) (Plaintiff failed to exhaust the grievance and appeal procedures established by the health maintenance organization).

C. *The Award Of Punitive Damages Under Conflicting And Inconsistent State Law Standards Would Interfere With ERISA's Civil Enforcement Scheme*

Congress provided uniform nationwide standards governing the duties and liabilities of plan sponsors, administrators, and fiduciaries; and Congress enacted a carefully crafted civil enforcement scheme which was intended to be exclusive so as to insure a uniform nationwide source of law. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. at 54-56. *See also Report* 533, *supra* at 12, 17, *reprinted*

in 1973 U.S. Code Cong. & Admin. News 4649, 4655. Congress recognized that benefit plans were increasingly interstate in nature and intended to promote the growth of benefit plans by providing a uniform set of standards and remedies. *Id.* The Alabama court's imposition of conflicting and inconsistent state law remedies arising out of the process of explaining plan coverages, benefits, and options would discourage the growth and development of benefit plans contrary to the express intent of Congress.

In *Massachusettes Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985), the Court held that ERISA Section 409, 29 U.S.C. § 1109(a), providing an action for breach of fiduciary duty, does not allow the recovery of extra contractual or punitive damages by a participant or beneficiary. The Court stated that, "The six carefully integrated civil enforcement provisions . . . provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." 473 U.S. at 146. The majority of the circuits have held that plan participants cannot recover extracontractual or punitive damages for claims, whether designated as state law claims or ERISA claims, that "relate to" the benefit plan. *Amos v. Blue Cross-Blue Shield of Alabama*, 868 F.2d 430, 431 n.2 (11th Cir.), *cert. denied*, 110 S.Ct. 158 (1989). The imposition of state law remedies allowing the award of ungoverned and unlimited punitive damages, such as Respondent's Alabama claims, for conduct occurring during the administration of a benefit plan and the explanation of options and coverages within that plan would emasculate Congress' carefully enacted enforcement mechanism and would discourage plans from offering new options or benefits which might subject them to devastating punitive awards. Whether or not Respondent would prevail on his potential claims for breach of ERISA's information disclosure and fiduciary responsibilities in this case, Congress intended that state law claims such as Respondent's would be preempted.

IV. The Alabama Court Plainly Misconstrued and Misapplied The ERISA Insurance Savings Clause In Direct Conflict With The Decisions Of This Court And Other Federal Appellate Courts

The Alabama court failed to address the question of whether Alabama's "twisting" statute, *Ala. Code* § 27-12-6 (1975), provides for a private cause of action.[4] Instead, having held that Respondent's common law fraud claim is not preempted, the Court opined that "if some other court" decides that such a fraud claim is preempted, "then we would hold that a claim under § 27-16-6 [sic] could still be maintained under the savings clause of ERISA as a state law regulating the business of insurance." App. at 16a. The Court so held even though HealthAmerica, a health maintenance organization, was not engaged in the business of insurance and did not issue policies of insurance. Second, the twisting statute does not meet *any* of the three McCarran-Ferguson Act factors applied by this Court to determine whether a state law regulates the "business of insurance." Third, the judicial creation of private remedies under trade practices acts would allow the different states to regulate the information disclosure and fiduciary standards specifically regulated by Congress and reserved to the federal government under ERISA. Simply put, to allow such remedies would devastate ERISA's exclusive enforcement scheme and the "savings clause" would consume the preemption clause.

In *Pilot Life*, and *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), the Court established a three tiered test to determine whether a state law is

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[4] This issue was extensively briefed and the Alabama court was well aware that the majority of courts nationwide recognize that a trade practices act does not support a private action unless expressly provided therein. *See Farlow v. Union Central Life Ins. Co.*, 874 F.2d 791 (11th Cir. 1989).

"saved" from ERISA preemption under Section 514(b)(2): First, a Court must take whatever guidance is available from a "common sense view" of the language of the savings clause itself; second, a Court must consider the case law interpreting the phrase "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. § 1012; third, and most significant, the Court must consider the relationship between the application of the specific state law and the role of the savings clause in ERISA as a whole.

"A common-sense view of the word 'regulate' would lead to the conclusion that, in order to regulate insurance, a law must not just have an impact on the business of insurance, but be specifically directed toward that industry." *Pilot Life*, 41 U.S. at 50. As the Court noted in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 230, n. 38, "[m]any aspects of insurance companies are regulated by state law, but are not the 'business of insurance.'" Alabama's twisting provision, whether applied to an insurance company or, as in the instant case, an entity not engaged in the business of insurance, does not "regulate" the "business of insurance" as that phrase is used in the narrowing context of McCarran-Ferguson or ERISA.

The first McCarran-Ferguson factor, "the spreading and underwriting of a policyholder's risk," in the one indispensable characteristic of insurance. *Royal Drug Co.*, 440 U.S. at 211-12. *See also Anschulz v. Connecticut General Life Ins. Co.*, 850 F.2d 1467 (11th Cir. 1988); *Powell v. Chesapeake & Potomac Telephone Co. of Virginia*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986). Even District Judge Acker in *Butler v. Fringe Benefits Plan, Inc.*, 701 F. Supp. 804 (N.D. Ala. 1988), a case relied on by the majority of the Alabama court, recognized that Alabama's twisting statute does *not*

spread or transfer policyholder risks.[5] Alabama's twisting statute does not regulate how insurers assign or transfer risks, establish reserves, or otherwise underwrite risks. To the contrary, the twisting provision is simply concerned with prohibiting certain practices in the solicitation of insurance policies and nothing more.

With regard to the second McCarran-Ferguson factor, this Court has observed that the core of the business of insurance is the "relationship between the insurer and the insured, the type of policy which could be issued, its reliability, interpretation, and enforcement." *Royal Drug Co.*, 440 U.S. at 215-16. *See also Pilot Life*, 481 U.S. at 51. Unlike the mandated benefits law "saved" in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), the twisting statute does not regulate the terms, provisions, or benefits available under a policy of insurance—those things integral to the insurer-insured relationship. Rather, according to the opinion of the Alabama court, the twisting statute somehow allows the imposition of a private remedy for certain prohibited practices.

In *Powell v. Chesapeake & Potomac Telephone Co. of Virginia*, the Fourth Circuit found that the Plaintiff's state law claims, including a claim under Virginia's Unfair Trade Practices Act, were not saved from preemption as they did not bear upon the "busines of insurance."[6]

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[5] The Alabama court chose to rely on Judge Acker's opinion in the *Butler* case even though the Court was aware that Judge Acker has a record of being reversed on ERISA matters: *Amos v. Blue Cross-Blue Shield of Ala.*, 681 F. Supp. 1515, *reversed*, 868 F.2d 430 (11th Cir. 1989); *Whett v. Goodyear Tire & Rubber Co.*, 676 F. Supp. 1119, 1132 (N.D. Ala. 1987) (Judge Acker was forced to reverse himself in face of overwhelming precedent).

[6] Plaintiff's claims included an alleged violation of Section 38.1-52.1 of the Virginia Unfair Trade Practices Act, which provides as follows: "No person shall make, issue, circulate . . . any estimate, illustration, circular, statement, sales presentation, omission, or comparison which (1) Misrepresent the benefits, advantages, conditions, or terms of any insurance policy." 780 F.2d at 422 n.4.

Similarly, in *Dennette v. Life of Indiana Ins. Co.*, 693 F. Supp. 959 (D. Colo. 1988), the Court held that claims under Colorado's code, including a claim under a statute which prohibited "[m]isrepresenting pertinent facts or insurance policy provisions relating to coverages at issue" were not saved from ERISA preemption because such state laws did not effect the transferring or spreading of policyholder risk and were not integral to the insurer-insured relationship because they did not seek to regulate the substantive terms of the insurance contract itself. *See also Keel v. Group Hospitalization Medical Services, Inc.*, 695 F. Supp. 223 (E.D. Va. 1988); *Rollo v. Maxicare of Louisiana, Inc.*, 695 F. Supp. 245 (E.D. La. 1988).

The twisting statute, as applied in this case, also fails to meet the third McCarran-Ferguson criteria. Although the Alabama Trade Practices Law is generally directed to the insurance industry, the twisting provision is not so restricted as it applies to any "person." The evidence was undisputed that HealthAmerica is a health maintenance organization and not an insurance company and did not issue any policy of insurance to Respondent or to the welfare benefit plan. There is authority that health maintenance organizations and other alternative health care providing arrangements are not generally considered engaged in the business of insurance for purposes of the McCarran-Ferguson Act. *Royal Drug Co.*, 440 U.S. at 225-26. The Alabama court impliedly held that HealthAmerica was engaged in the busines of insurance and subject to state insurance regulations even though it did not discuss this question or cite any authority for the proposition that HMOs are subject to such regulation. Further, Alabama's twisting statute would not be saved *even if* HealthAmerica was an insurance company engaged in the busines of insurance because the statute fails to satisfy the other two McCarran-Ferguson factors.

Additionally, a claim for punitive damages against an ERISA administrator or fiduciary based upon violation of

a state insurance trade practices act provision, even *if* the state law otherwise satisfied the above criteria, would be preempted because of its disruption of ERISA's exclusive civil enforcement scheme. *Kanne v. Connecticut General Life Ins. Co.*, 859 F.2d 96 (9th Cir. 1988), *cert. denied*, 109 S.Ct. 3216 (1989); *Commercial Life Ins. Co. v. Juliano*, 764 P.2d 1059 (Cal. 1988), *cert. denied*, 109 S.Ct. 2087 (1989).

As shown above, the disclosure of information to plan participants concerning plan coverages and options is specifically governed under ERISA, as is the standard of conduct which governs ERISA fiduciaries in their dealings with plan participants, and Respondent may have a claim under ERISA's enforcement scheme for violation of these areas specifically regulated by Congress. Accordingly, it appears that the ERISA "deemer clause," 29 U.S.C. § 1144(b)(2)(B), may also be implicated as "the deemer clause guards against any insurance regulation that infringes on such ERISA areas as reporting, disclosure, and non-forfeitability." *FMC Corp. v. Holliday*, 885 F.2d 79, 88 (3rd Cir. 1989). To the extent that Alabama's twisting statute purports to treat HealthAmerica as an insurance company and purports to regulate HealthAmerica's conduct in the explanation of coverages and administration of benefits under the MPR welfare benefit plan, the deemer clause may require the preemption of Alabama's twisting provision even *if* said provision was otherwise saved from ERISA preemption as a law regulating the business of insurance.

As the dissent in this case indicated, Respondents' claim should be remanded to the trial court for determination of his remedies under ERISA's civil enforcement scheme. In the unlikely event that Respondent's situation is not governed by ERISA's information and fiduciary standards or enforcement scheme, it is within the power of Congress to broaden the information requirements or expand the enforcement scheme. Additionally, the federal courts have

a duty to develop the federal common law of ERISA to fulfill the purposes of the Act. However, regardless of whether Respondent will prevail in an ERISA action against Petitioners, Congress has expressly preempted his state law claims; and the conflict in the application of federal law, created by the Alabama court, must be resolved.

V. The Disproportionate Punitive Damages Award And The Alabama Standard Governing Punitive Damages Awards For Civil Fraud Violate The Due Process Clause Of The Fourteenth Amendment

The punitive damages award represents 745 times the amount of Plaintiff's actual damages and was made based upon a punitive damages standard which is incomprehensibly vague and unintelligible.[7] The verdict is so grossly disproportionate to the character of Petitioners' alleged misconduct as to be constitutionally excessive and to violate Petitioners' rights to substantive due process. *See Browning-Ferris Industries v. Kelco, Inc.*, 109 S.Ct. 2909 (1989). Further, Petitioners were given no warning that their conduct would be subject to such penalties, and the absence of a meaningful standard resulted in the deprivation of Petitioners' "property" rights without due process of law.

Fundamental to the concept of due process is an element of fair warning and notice of what conduct will give rise to punishment so that a person of ordinary intelligence would have a reasonable opportunity to understand what conduct is prohibited. *See Grayned v. City of Rockford*, 408 U.S. 104, 108-109 (1972); *Giacco v. Pennsylvania*, 382 U.S. 399, 402-403 (1977).[8] The Ala-

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[7] The meaningless standard customarily applied in Alabama is stated in the opinion, App. A, 22a-24a: "so recklessly done as to amount to the same thing" as intentional fraud.

[8] Although Defendants' constitutional issues were first raised post-trial, the trial judge carefully considered them and specifically

bama standard allowing the imposition of punitive damages for fraud does not provide a rational or intelligible standard for the jury to use in determining whether to award punitive damages and fails to provide potential Defendants with an adequate notice of what conduct will subject them to punitive sanctions.

A law is unconstitutionally vague "when men of common intelligence must necessarily guess as to its meaning and differ as to its application." *Connally v. General Construction Co.*, 269 U.S. 385, 391 (1926); *Coates v. City of Cincinnati*, 402 U.S. 611 (1971); *Davis v. Schnell*, 81 F. Supp. 872 (S.D. Ala.), *aff'd per curiam*, 336 U.S. 933 (1949). Anyone of "common intelligence" would have to "guess" as to the meaning of the standard used in Alabama, as the jury did in this case. As a result of such a "standard," juries are given an unrestrained license to impose their own personal biases and prejudices against unpopular Defendants.[9]

VI. The Alabama Procedure Allowing The Jury Ungoverned And Unlimited Discretion In Awarding Punitive Damages For Civil Fraud Violates The Due Process Clause Of The Fourteenth Amendment

The jury had unlimited discretion in determining the amount of punitive damages awarded to Menton.[10] One

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held that they were "timely" raised. App., at 48a. Further, there is ample precedent to support the power of this Court to consider these issues. *Hathorn v. Lovorn*, 457 U.S. 255, 262-65 (1982).

[9] Plaintiff's counsel repeatedly referred to Defendant Health-America as an "insurance company" at trial even though Health-America is a health maintenance organization.

[10] In 1987, the Alabama legislature enacted "tort reform" statutes which capped punitive damage awards at $250,000.00, with exceptions, and imposed a "clear and convincing evidence" standard for the award of punitive damages. Ala. Code Ann. §§ 6-11-20; 6-11-21 (Supp. 1989). However, these statutes do not apply to the case at bar. Ala. Code Ann. § 6-11-30 (Supp. 1989). Further, the statute capping punitive damage awards is currently under attack in at

court has held that due process places a limit on punitive damage awards in some contexts. *See Juzwin v. Amtorg Trading Corp.*, 705 F. Supp. 1054, 1064, *reh'g granted*, 718 F. Supp. 1233 (D.N.J. 1989). Further, Petitioners submit that the Alabama punitive damages scheme chills their "fundamental right of access to the courts by authorizing unlimited punitive damages," and members of this Court have noted the amount of jury discretion in awarding punitive damages "may violate the Due Process Clause." *See Bankers Life & Casualty v. Crenshaw*, 486 U.S. 71, 108 S.Ct. 1645, 1655 (1988) (O'Connor, J., dissenting); *see also Browning-Ferris Industries v. Kelco, Inc.*, 109 S.Ct. 2909 (1989).

As a matter of common law in Alabama, punitive damages are intended to punish a civil defendant and deter future similar conduct. *See Aetna Life Ins. Co. v. Lavoie*, 470 So.2d 1060 (Ala. 1984), *rev'd.*, 475 U.S. 813 (1986); *Badgett v. McDonald*, 304 So.2d 228 (Ala. Civ. App. 1974). However, under Alabama's scheme Petitioners were not provided any semblance of the procedural and substantive safeguards afforded criminal defendants before they can be punished: The jury was not given meaningful guidelines to apply in determining the award of punitive damages; there was no limit on the amount which could be awarded; there was no requirement that the punitive award bear any particular relationship to the amount of actual damages; there was no increased burden of proof required for the imposition of such punishment; and there was no meaningful appellate review of the jury's excessive award. Such a scheme violates the Due Process Clause of the Fourteenth Amendment.

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least one court in Alabama. *Trawick v. Michaels of Oregon Co.*, No. 88-C-413-N (N.D. Ala. 1989). If that statute is struck down, then the unbridled and standardless scheme approved in *Menton* will again apply in Alabama.

CONCLUSION

As Alabama Supreme Court Justices Houston and Maddox recognized, the Supremacy Clause of the United States Constitution should have prevented the majority of the Alabama court from adopting its own narrow standard of ERISA preemption, contrary to the intent of Congress and the great weight of federal authority. App. at 29a. The irreconcilable conflict in the application of federal law created by the majority of the Alabama court must be resolved. This Court should also grant review of the punitive damages award in this case. The impermissively excessive award resulted from a pernicious scheme devoid of meaningful standards or procedures for the protection of the property rights of civil defendants.

For all of the foregoing reasons, a writ of certiorari should issue to review the judgment and opinion of the Supreme Court of Alabama.

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APPENDICES

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APPENDIX A

THE STATE OF ALABAMA
JUDICIAL DEPARTMENT
THE SUPREME COURT OF ALABAMA

SPECIAL TERM, 1989

87-1100

HEALTHAMERICA and PAMELA MERLE

v.

EDWARD MENTON

Appeal from Mobile Circuit Court
(CV-86-003049)

SHORES, JUSTICE.

The plaintiff/appellee, Edward Menton, was employed as city editor for the *Mobile Press Register* newspaper ("Press Register"). As part of his employment, Menton was provided with medical insurance coverage, for which the Press Register paid 50 to 60 percent of the premiums and the balance was deducted from Menton's salary. In June 1985, the Press Register offered an alternative medical benefit selection, which allowed qualified Press Register employees either to keep the medical insurance that they had, or to cancel it and enroll in one of the two health maintenance organizations then in the Mobile area, Prime Health and defendant/appellant, HealthAmerica, without suffering an interruption of benefits.

Menton had a son, Jacob, whose premature birth necessitated a series of surgical operations to lengthen and straighten the tendons in his legs and feet. After each such operation, and after his casts were removed, Jacob would undergo physical therapy treatments three times a week until he was ready for his next surgical operation.

Menton's health insurance under the Press Register's employment benefit plan paid 80% of the cost of Jacob's physical therapy treatments and orthopedic appliances. Jacob's second operation was imminent when the Press Register employees were offered alternative coverage by either of the health maintenance organizations. HealthAmerica's list of physicians included both of the physicians who had been treating Jacob's legs; Prime Health's did not. Menton read the promotional literature regarding HealthAmerica's coverage but could not determine from that whether HealthAmerica would provide coverage for Jacob's physical therapy and orthopedic appliances.

At the suggestion of the assistant general manager of the Press Register, who had initially reviewed the coverage provided by HealthAmerica and had helped HealthAmerica distribute information about its plan to the Press Register employees, Menton attended an informational meeting of Press Register employees three days before Jacob's second surgery. This meeting was presided over by defendant/appellant Pamela Merle, who had worked for HealthAmerica for approximately one and one-half months prior to this meeting. During the meeting, the Press Register employees were repeatedly told that the coverage provided by the health maintenance organizations such as HealthAmerica and Prime Health was generally the same as, or was better than, the medical coverage that Menton and other employees had. After the meeting, Menton asked Merle specific questions about HealthAmerica's coverage of Jacob's medical expenses. He explained Jacob's medical history, his im-

pending operation, and his need for extensive physical therapy and orthopedic appliances after his second surgery. In response to a direct question from Menton, Merle informed Menton that Jacob's medical expenses would be "covered one hundred percent by HealthAmerica."

In reliance upon Merle's representations, Menton dropped his health insurance and enrolled in the HealthAmerica plan. After Menton enrolled in the HealthAmerica plan, he received a schedule of benefits in the mail. On reviewing the schedule, Menton noticed that outpatient services for physical therapy were apparently covered for only 60 days. Menton attempted to get HealthAmerica to provide the coverage that he had been promised when he dropped his previous insurance, which provided coverage for 80% of Jacob's physical therapy expenses for an unlimited period of time. HealthAmerica extended coverage for 60 additional days after the initial 60-day period, but would not provide coverage beyond that. Jacob's physical therapy expenses amounted to approximately $150 a week.

Menton filed this suit against HealthAmerica and its agent, Merle, in which he alleged a state common law action for fraud, asserting misrepresentations of a material fact made willfully to deceive, or recklessly without knowledge, that caused him to drop the hospital coverage he had under an insured employment benefit plan and to elect the HealthAmerica coverage also provided under the plan. The defendants pleaded the general issue and preemption by the Employee Retirement Income Security Act of 1974 ("ERISA"), 88 Stat. 829 as amended, 29 U.S.C. § 1001 *et seq.* Menton did not file a claim under ERISA. Predicated on the ERISA preemption, the defendants moved for a directed verdict at the close of Menton's case and at the close of all the evidence. The trial court observed that the Alabama Health Maintenance Organizations Statutes ("HMO Statutes"), Code

1975, §§ 27-21A-1 to 27-21A-32, and the Alabama "twisting" statute, Code 1975, § 27-12-6, might be saved by § 514(b) of ERISA if Menton's claim were subject to ERISA preemption; overruled the defendants' motions for a directed verdict; and submitted the case to the jury with instructions on Alabama civil actions for misrepresentation, without reference to the HMO statutes or the twisting statute. The jury returned a verdict in favor of Menton. After final judgment was entered, Menton filed a motion to amend his complaint to conform to the evidence, alleging a violation of § 27-12-6, the "twisting" statute. The defendants' objection to this was overruled, as was their motion for a judgment notwithstanding the verdict or in the alternative for a new trial.

The first issue presented by this case is whether ERISA preempts a state common law action for fraud where the plaintiff alleges that he relied on misrepresentations made by the defendants in dropping his old hospital insurance and electing coverage under the defendants' plan. We hold that a claim for fraud in the inducement does not "relate to" an employee benefit plan and is therefore not preempted by ERISA.

The courts in Alabama have recognized a common law right of action for fraud, at least since the case on *Einstein, Hirsch & Co. v. Marshall & Conley*, 58 Ala. 153 (1877), when Justice Stone criticized the old case of *Chandelor v. Lopus*, 1 Smith Lead. Cas. 319 (9th ed. 1889) (adjudged in the Court during the Reign of James the First), which involved alleged fraud in the sale of a stone, which the seller represented as a bezoar stone and sold as such. All the Barons, except Anderson, in the Court of Exchequer held that " 'the bare affirmation that it was a Bezoar stone, without warranting it to be so, is no cause of action; and although he knew it to be no Bezoar stone, it is not material.' " 58 Ala. at 160 (quoting *Chandelor v. Lopus*). To this Justice Stone wrote, "We submit, if this language does not sanction looser

morals than the present state of the law will justify." 58 Ala. at 160. To make certain that it did not sanction those looser morals of *Chandelor v. Lopus*, the legislature of Alabama in 1907 codified laws that it had enacted that provided civil actions for fraud (now Code 1975, § 6-5-100), for misrepresentations of material fact (now § 6-5-101), for suppression of material facts (now § 6-5-102), and for deceit (now § 6-5-103).

With ERISA, Congress imposed comprehensive federal oversight of employee benefit plans of employers engaged in interstate commerce. Under ERISA Section 502(a), as set forth in 29 U.S.C. § 1132(a)(1)(B), a civil action may be brought by a participant or beneficiary "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." This limits the options of the employee, who is preempted from brigning actions under state laws when they "relate to" any employee benefit plan.

ERISA's preemption provision states:

> "Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ."

29 U.S.C.A. § 1144(a).

The defendants argue that Menton is preempted under this ERISA preemption provision from filing a state common law action for fraud. Under the facts of this case, the Press Register is engaged in interstate commerce; the undisputed evidence shows that the Press Register solicits advertisements from outside Alabama, advertises for businesses located outside Alabama, and sells its papers outside Alabama. Menton was a full-time employee of the Press Register, and the Press Register had

an employee benefit plan prior to and after Menton enrolled in the HealthAmerica plan.

Therefore, we must determine whether his claim is preempted by ERISA. The defendants rely upon *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987), wherein the Supreme Court ruled that a state lawsuit asserting improper processing of a claim for benefits under an ERISA-regulated plan was preempted by federal law. In *Pilot Life* the Supreme Court held that the phrase "relate to" is to be given its "'broad common-sense meaning, such that at state law "relate[s] to" a benefit plan "in the normal sense of the phrase, if it has a connection with or reference to such a plan."'" 481 U.S. at 47, citing *Metropolitan Life Insurance Co. v. Massachusetts*, infra, and *Shaw v. Delta Air Lines, Inc.*, infra.

The United States Supreme Court had considered ERISA's preemption provision three times prior to *Pilot Life*: *Alessi v. Raybestos Manhattan, Inc.*, 451 U.S. 504, 101 S.Ct. 1985, 68 L.Ed.2d 402 (1981); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S. Ct. 2890, 77 L.Ed.2d 490 (1983); and *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985).

In *Shaw v. Delta Air Lines, Inc.*, the Court noted that "[s]ome state actions may affect employee benefits in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." 463 U.S. at 100 n.21. In *Shaw*, the Court cited with approval *American Telephone & Telegraph Co. v. Merry*, 592 F.2d 118 (2d Cir. 1979), in which the Second Circuit Court of Appeals held that ERISA did not preempt a state's garnishment of a spouse's benefit plan income to enforce alimony and support orders. In accord, see, *Savings & Profit Sharing Fund of Sears Employees v. Gago*, 717 F.2d 1038 (7th Cir. 1983); *Howard v. Parisian, Inc.* 807 F. 2d 1560 (11th Cir. 1987); *Sommers Drug Stores Co.*

Employee Profit Sharing Trust v. Corrigan Enterprises, Inc., 793 F. 2d 1456 (5th Cir. 1986), *cert. denied*, 479 U.S. 1034, 107 S.Ct. 884, 93 L.Ed.2d 837 (1987).

HealthAmerica argues that *Pilot Life* forecloses debate and that Menton's claim is preempted by ERISA as one "relating to" an employee benefit plan. We disagree. *Pilot Life* involved an individual who was receiving benefits under a plan insured by the Pilot Life Insurance Company. In 1975, Everate W. Dedeaux injured his back in an accident related to his employment with Entex, Inc. Entex sponsored a long-term disability plan that qualified as an employee benefit plan under ERISA, for employees who became permanently disabled. While Entex assumed responsibility for the disability plan's day-to-day operation and administration, benefits under the plan were provided by a group insurance policy issued by Pilot Life Insurance Company.

Following Dedeaux's accident, Pilot Life provided benefits to him for two years. His benefits under the plan were first interrupted, then terminated altogether. When they were discontinued, Dedeaux sued Pilot Life. Although the complaint in *Pilot Life* contained a count for "fraud in the inducement," the opinion makes it unmistakably clear that the only claims he pursued were claims seeking damages for improperly processing his claims for benefits under an ERISA-regulated plan. Justice O'Connor, writing for the Supreme Court, stated as follows:

> "Although Dedeaux's complaint pled several state common law causes of action, before this Court Dedeaux has described only one of the three counts—called 'tortious breach of contract' in the complaint, and 'the Mississippi law of bad faith' in respondent's brief—as protected from the pre-emptive effect of § 514(a). The Mississippi law of bad faith, Dedeaux

> argues, is a law 'which regulates insurance,' and thus is saved from pre-emption by § 514(b)(2)(A)."

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. at 48, 107 S.Ct. 1549, 1553, 95 L.Ed.2d 39, at 48 (footnote omitted). Having considered this single count, the Court held:

> "[W]e conclude that Dedeaux's state law suit asserting improper processing of a claim for benefits under an ERISA-regulated plan is not saved by § 514(b)(2)(A), and therefore is pre-empted by § 514(a)."

Id. 481 U.S. 41, at 57, 107 S.Ct. 1549 at 1558, 95 L.Ed.2d 39, at 54 (footnote omitted).

Pilot Life merely cleared the confusion that *Metropolitan Life* had created in the lower federal courts. Following *Metropolitan Life*, several lower courts held that insurance companies serving as claims review fiduciaries to fully insured employee benefit plans were subject to the full measure of state remedies, while fiduciaries of self-insured plans were not. *Pilot Life* rejected the artificial distinction between fully-insured and self-insured plans created by *Metropolitan Life*.

In this case, Menton does not claim improper processing of a claim, nor any benefits under the terms of the plan. To the contrary, he claims he was fraudulently induced to drop his existing coverage by misrepresentations made by the defendants to him prior to his becoming a member of the HealthAmerica plan. This is the clear distinction between this case and *Pilot Life*.

The Supreme Court has not drawn a hard, clear line as to which state law is preempted by § 514(a). This is demonstrated by the case of *Ft. Halifax Packing Co. v. Coyne*, 482 U.S. 1, 107 S. Ct. 2211, 96 L.Ed.2d 1 (1987), which was decided two months after *Pilot Life*. In *Ft. Halifax*, the Court held that a Maine statute requiring employers to make a one-time severance payment to employees when a plant closed was not preempted

by ERISA. The Court noted that the preemption clause expressly states that state laws are superseded to the extent that they "relate to any employee benefit plan." The Court stated that the preemption provision "does not refer to state laws relating to 'employee benefits,' but to state laws relating to 'employee benefits plans.'" *Id.*, at 7. (Emphasis in original.) The Court observed that ERISA uses the words "benefit" and "plan" separately throughout and nowhere treats the two as synonymous. "Given the basic difference between a 'benefit' and a 'plan,' 'Congress' choice of language is significant in its pre-emption of only the latter." *Id.* at 8, 107 S. Ct. at 2216, 96 L.Ed.2d at 9 (1987).

The distinction made by the Court in *Ft. Halifax*, between laws that relate to employee benefits *plans* and laws that relate simply to employee *benefits*, is analogous to the instant case and demonstrates why Menton's claim for fraudulent inducement does not "relate to" Health-America's plan.

Teper v. Park West Galleries, Inc., 431 Mich. 202, 427 N.W. 2d 535 (1988), presented a much closer question on preemption than exists here. In that case the Michigan Supreme Court held that a plaintiff's claim against her employer for breach of an employment contract, which claimed, in part, compensation for future pension benefits, was not preempted by ERISA. The court held that "the simple fact that the damage award was based in part upon the terms of the plan does not place any fiscal or administrative burden upon the plan itself. This relationship to the plan is, in the words of the *Shaw* Court, too 'peripheral' to trigger ERISA preemption." 431 Mich. at 208, 427 N.W.2d at 541. Chief Justice Riley, concurring with the majority in *Teper*, found ERISA's definition of a "state" important for the purposes of the ERISA preemption clause:

> "Congress has further explained the scope of ERISA preemption in the definitional section, 29 U.S.C.

> § 1144(c)(2), wherein the term 'state' for preemption purposes is characterized as 'a State, any political subdivision thereof, or any agency or instrumentality of either, *which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.*' "

431 Mich. at 212, 427 N.W.2d at 545 (emphasis in original).

In *Quigley v. UNUM Life Ins. Co.*, 688 F. Supp. 80 (D. Mass. 1988), the plaintiff's decedent was a participant in a retirement pension plan. Plaintiff's decedent received eight years' of monthly annunity payments following his retirement. Following his death, his estate brought an action against UNUM for breach of contract and misrepresentation. UNUM contended that the claims were preempted by ERISA. The federal district court rejected UNUM's preemption argument, finding that the plaintiff's causes of action were "so tenuously related to an ERISA plan that the claims are not preempted." *Id.*, at 82. In so holding the court found:

> "The dispute in this case does not involve the plan and the plaintiffs do not claim that any term of the pension plan was violated. . . . Litigation of these issues will not, in effect, result in state regulation of the pension plans contrary to the purposes of ERISA. The concern which motivated the enactment of the ERISA preemption provisions, the threat of inconsistent and conflicting state regulations of ERISA plans, is not implicated if this action is allowed to go forward. *See Ft. Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 107 S. Ct. 2211, 2216, 96 L. Ed. 2d 1 (1987)."

Id., at 82-83.

In *Greenblatt v. Budd Co.*, 666 F. Supp. 735 (E.D. Pa. 1987), the plaintiff sued his employer for misrepresenting to him that the benefits he was receiving under one of

two pension plans would be made equal to those available under the other plan. The Court, after first acknowledging that the Supreme Court has determined that "Congress made the preemption provision 'deliberately expansive' and 'designed to "establish pension plan regulation exclusively as a federal concern,"'" *id.*, at 741, quoting *Pilot Life*, rejected the employer's argument that ERISA preempted the plaintiff's claim:

> "The cause of action for misrepresentation alleged by the plaintiff at Count II of his complaint should not be preempted because, simply put, the premise underlying this action was that plaintiff was deceived by the verbal statements made and the actions taken by his employer. That the subject of the deception concerned pension benefits is only incidental and not essential to the plaintiff's cause of action. Like promises for a raise in salary, a promotion, or the use of tickets to a baseball game, plaintiff's employer's promise to provide the plaintiff with certain benefits at some unknown time in the future, upon which the plaintiff could reasonably rely, is the essence of the fraud alleged."

Id., at 742. In accord: *Morningstar v. Meijer, Inc.*, 662 F. Supp. 555 (E.D. Mich. 1987) (plaintiff's claim for breach of employment contract against former employer did not "relate to" ERISA plan, despite the fact that plaintiff claimed as part of her damages the value of certain future fringe benefits under an ERISA plan); *McNamee v. Bethlehem Steel Corp.*, 692 F. Supp. 1477 (E.D. N.Y. 1988) (plaintiff claimed fraudulent misrepresentation by employer that upon rehiring he would suffer no break in pension coverage, and court found that because plaintiff's claims did not "seek benefits under the plan" his claim was not preempted).

Courts nationwide continue to struggle with ERISA preemption issues occasioned by the "relate to" language in Section 514(a). See: *Springer v. Wal-Mart Assoc.*

Group Health Plan, [No. 88-AR-5226, June 6, 1989] —— F. Supp. —— (N.D. Ala. 1989); *Amos v. Blue Cross-Blue Shield of Alabama*, 681 F. Supp. 1515 (N.D. Ala. 1988), rev'd, 868 F.2d 430 (11th Cir. 1989); *Farlow v. Union Central Life Ins. Co.*, 874 F.2d 791 (11th Cir. 1989); *Anschultz v. Connecticut General Life Ins. Co.*, 850 F.2d 1467 (11th Cir. 1988); *Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir. 1987); *Jordan v. Reliable Life Ins. Co.*, 694 F. Supp. 822 (N.D. Ala. 1988); *Graves v. Blue Cross of California*, 688 F. Supp. 1405 (N.D. Cal. 1988); *Mackey v. Lanier Collections Agency & Service, Inc.*, 486 U.S. ——, 108 S. Ct. 2182, 100 L. Ed.2d 836 (1988); *Board of Trustees of Cedar Rapids Pediatric Clinic, P.A., Pension Plan v. Continental Assurance Co.*, 690 F. Supp. 792 (W.D. Ark. 1988); *Perry v. P*I*E Nationwide, Inc.*, 872 F.2d 157 (6th Cir. 1989); *Idaho Plumbers and Pipefitters Health and Welfare Fund v. United Mechanical Contractors, Inc.*, 875 F.2d 212 (9th Cir. 1989); *Totton v. New York Life Ins. Co.*, 685 F. Supp. 27 (D. Conn. 1987); *Tesch v. General Motors Corp.*, 685 F. Supp. 1084 (E.D. Wis. 1988); *Southern California Meat Cutters Unions & Food Employers Pension Trust Fund v. Investors Research Co.*, 687 F. Supp. 506 (C.D. Cal. 1988); *Hall v. Pennwalt Group Comprehensive Medical Expense Benefits Plan*, (E.D. Pa. 1989); *Schultz v. Boesken Elec. Co.*, 703 F. Supp. 656 (S.D. Ohio 1988); *Urban Health Services, Ltd. v. Travelers Ins. Co.*, 703 F. Supp. 53 (N.D. Ill. 1989); *Holmes v. Pacific Mut. Life Ins. Co.*, 706 F. Supp. 733 (C.D. Cal. 1989); *Seafarers' Welfare Plan v. Dixon*, 512 So. 2d 53 (Ala. 1987); *Davidian v. Southern California Meat Cutters Union & Food Employees Benefit Fund*, 859 F. 2d 134 (9th Cir. 1988); *Hood v. Prudential Ins. Co. of America*, 522 So.2d 265 (Ala. 1988); *Landy v. Travelers Ins. Co.*, 530 So. 2d 214 (Ala. 1988); *Massachusetts v. Morash*, 490 U.S. ——, 109 S.Ct. 1668, 104 L.Ed.2d 98, (Mass. 1989). Although there is authority on both sides, the better reasoned cases, and those which

recognize the dual role of state and federal law after ERISA, have reached the conclusion that we have reached today.

Authors Kilberg and Inman in their Observations, *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514*, 62 Tex.L. Rev., at 1328-30 (1984), suggest that the Act contemplates a different approach to these cases. They argue, and we agree, that the Act itself provides a better formula for discerning which state cases are preempted and which are not:

> "Although the courts often have turned to the 'indirectly' language of section 514(c)(2) in their analysis, they have largely ignored another critical word contained in the same clause. Section 514(c)(2) defines a 'State' as an entity that '*purports* to regulate, directly or indirectly, the terms and conditions' of the plan.
>
> "An inquiry into the significance of the word 'purports' sheds considerable light on the elusive 'relate to' language of section 514(a). 'Purport' has two ordinary meanings: 'to . . . imply or profess outwardly' and 'to have in mind.' Both meanings comprehend purpose—the first speaks to apparent purpose, the second to actual purpose or intent. In the state law context, an apparent purpose to regulate, manifested by a reference to employee benefit plans in the text of the law, invariably reflects an actual regulatory purpose. Hence, any law expressly directed toward employee benefit plans 'purports' to regulate the plans within the meaning of section 514.
>
> "Congress meant to preempt such state laws, however, whether or not they are styled as employee benefit plan regulations. In light of this congressional intent, 'purports' must be construed in its 'normal sense' of 'to have in mind.' This construc-

tion necessitates an inquiry into the actual legislative or judicial purpose underlying the state law in question. To determine whether the purpose of a state law is to regulate benefit plans, a court should identify what the law seeks to accomplish and ask whether the law presupposes the existence of benefit plans to achieve that aim. If the purpose of the law is to affect the terms and conditions of employee benefit plans, the law may be found to 'relate to' the plans under section 514 (a). If such a purpose is absent, the 'relate to' requirement will not be met and the law will not be preempted, even though it may have some tangible effect on benefit plans.

"This purpose-effect distinction serves well to identify those state 'legislative' laws that Congress intended to preempt with section 514. In addition, this approach is useful in determining whether section 514 preempts a state court or agency application of an otherwise valid state law to a benefit plan. In these adjudicative settings, a second 'State Law' emerges that seeks to impose a provision of state law on the plan irrespective of the plan's terms. Such state adjudications invariably 'purport' to regulate the plan and consequently should be preempted under section 514(a). State adjudicative decisions raise a different issue, however, when the decisions are grounded in the terms of the plan itself, rather than in the terms of the state law applied to the benefit plan. The question then arises whether this act of interepresentation itself constitutes a state law that 'relates to' the plan. This problem is treated in the following subpart.

"Section 502(a)(1)(b) provides that a participant or beneficiary of a plan may bring a civil action 'to recover benefits due to him *under the terms* of his plan, to enforce his rights *under the terms* of the plan, or to clarify his rights to future benefits

under the terms of the plan. . . .' Section 502(e)(1) provides that this civil action may be brought in either federal or state court. To reconcile this grant of concurrent jurisdiction with section 514's preemption of state laws that regulate the terms and conditions of a plan, state court decisions that merely interpret the terms of the plan in order to adjudicate the rights of a participant or beneficiary must be deemed not to regulate the plan's terms and conditions. Any other conclusion would reduce the grant of concurrent jurisdiction to surplusage: decisions sanctioned by sections 502(a)(1)(B) and 502(e)(1) would be preempted by section 514.

"Thus, the jurisdictional sections of ERISA, by allocating authority to the state courts to interpret the terms of a plan, imply that interpretation alone does not constitute regulation of the terms and conditions of a plan. If interpretation is not regulation of the plan's terms when federal and state courts have concurrent jurisdiction, there is no basis for a different conclusion when the state court interprets the terms of a plan in a case over which only the state court has jurisdiction. Thus, although the states are barred from regulating employee benefit plans, they are invited to construe the plans' terms, a task that often entails construing ERISA's requirements. The states can, therefore, create decisional law, but they may not apply existing state law, decisional or otherwise, that overrides the terms of the plan."

Neither Alabama's fraud statute nor the common law action for fraud purports to regulate, directly or indirectly, the terms and conditions of a plan, and the application of Alabama's fraud law to the facts of this case does not relate to or affect the administration of the plan.

The analysis suggested by Kilberg and Inman would promote the policy endorsed by the United States Supreme Court in *Ft. Halifax*: "ERISA pre-emption analysis 'must be guided by respect for the separate spheres of government authority preserved in our federalist system.'" 482 U.S. at ——, quoting *Alessi v. Raybestos-Manhattan, Inc., supra.* It is equally consistent with the Court's decision in *Metropolitan Life Insurance Co. v. Massachusetts*, where the Court stated: "We must also presume that Congress did not intend to preempt areas of traditional state regulation." 471 U.S. at 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985).

The defendants argue that the trial court erred in allowing Menton to amend his complaint after final judgment was entered, to allege a violation of the "twisting" statute, § 27-12-6. The trial court did not err, for two reasons. The first is that every element underlying the "twisting" statute is included in the plaintiff's complaint stating a common law cause of action for fraud, now codified at § 6-5-101 (misrepresentations of a material fact made willfully to deceive, or recklessly without knowledge). Therefore, the amendment to the complaint alleging violation of § 27-12-6 was redundant, and it could not have prejudiced the defendants in any way. Second, if it is assumed for purposes of argument, or if some other court decides that a claim under § 6-5-101 or its common law counterpart is preempted by section 514(a) of ERISA, then we would hold that a claim under § 27-16-6 could still be maintained under the saving clause of ERISA as a state law regulating the business of insurance:

> "[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance. . . ."

Section 514(b)(2)(b), 29 U.S.C. § 1144(b)(2)(A).

The purpose of Chapter 12 ("Trade Practices Law") of Title 27 ("Insurance") of the Alabama Code is expressed in § 27-12-1(a):

> "The purpose of this chapter is to regulate trade practices *in the business of insurance* in accordance with the intent of congress as expressed in the Insurance Regulation Act by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined." (Emphasis added.)

Section 27-12-6 ("Twisting") provides as follows:

> "No person shall make or issue, or cause to be made or issued, any written or oral statement misrepresenting or making misleading incomplete comparisons as to the terms, conditions, or benefits contained in any policy for the purpose of inducing, or attempting or tending to induce, the policyholder to lapse, forfeit, surrender, retain, exchange or convert any insurance policy."

Section 27-1-2(3) defines "person" for the purposes of Title 27 as follows:

> "An individual, insurer, company, association, organization, Lloyd's insurer, society, reciprocal insurer or interinsurance exchange, partnership, syndicate, business trust, corporation and every legal entity."

The United States Supreme Court in *Pilot Life* looked to "common sense" and to the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, in interpreting the saving clause, and in doing so it used the following criteria to determine whether a practice falls under the "business of insurance":

> "'[F]irst, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry."

Pilot Life, 481 U.S. at 48, 107 S. Ct. at 1553-54, 95 L.Ed.2d at 48 (1987) (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.W. 119, 129 (1982)). The legislature of Alabama, in adopting the "twisting" statute § 27-16-6, has enacted a fraud and misrepresentation statute that specifically relates to the insurance industry and, therefore, we believe it is "saved" from preemption by a proper interpretation of § 514(b).

We acknowledge that the Eleventh Circuit Court of Appeals has held in *Farlow v. Union Cen. Life Ins. Co.*, [No. 88-7513, June 6, 1989] —— F.2d —— (1989), that the Alabama "twisting" statute does not create a private cause of action and that, if it did, a claim under it would be preempted under ERISA if the employer's conduct giving rise to the claim was not "wholly remote in content" from the benefit plan. Presumably, under this holding, the commissioner of insurance would be preempted from imposing the statutory sanctions against insurance companies that violate § 27-12-1 et seq. We are unconvinced that Congress intended this result.

We recognize that the cases from the various federal courts are disparate. We adopt the position taken by the Sixth Circuit on the precise issue involved in this case: fraud in the inducement. *Perry v. P*I*E Nationwide, Inc.*, 872 F.2d 157 (6th Cir. 1989). In that case, the plaintiffs alleged that the defendant had fraudulently induced them to participate in a plan covered by ERISA. The defendants claimed preemption under § 514(a). The district court held that "preemption by ERISA applies only once the benefit plan is in existence" and does not

apply to alleged common law actions of fraud or misrepresentation "to get the plaintiffs to join the plan." Because the purported misconduct of P*I*E occurred before the plaintiffs became participants or beneficiaries, and because they were not suing for benefits under the plan, the district court had held that preemption did not apply. In accord, *Butler v. Fringe Benefits Plan, Inc.*, 701 F.Supp. 804 (N.D. Ala. 1988).

The Circuit Court of Appeals for the Sixth Circuit affirmed, citing *Miller v. Lay Trucking Co.*, 606 F.Supp. 1326 (N.D. Ind. 1985) (holding that the plaintiff's common law action for fraudulent inducement was not preempted by ERISA because the fraud occurred prior to the time the plaintiff entered the plan, and because the fraud claim did not directly affect the regulation of the ERISA plan).

The Sixth Circuit acknowledged, as we do, that there is respectable authority for the positions taken by both sides concerning preemption of state common law claims of fraud, etc.[1] It adopted in *Perry* the position expressed in *Dependahl v. Falstaff Brewing Corp.*, 653 F.2d 1208 (8th Cir.), *cert. denied*, 454 U.S. 986, 102 S.Ct. 512, 70 L.Ed. 2d 384 (1981), that preemption should apply to a state law claim only if Congress has provided a remedy for the wrong or wrongs asserted.

Congress has not provided a remedy for the wrong asserted by Mr. Menton, and we are loath to imply an intent on its part to do so.

We next address the defendants' contention that the trial court erred in denying the defendants' motion for a

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[1] *Cefalu v. B. F. Goodrich Co.*, 871 F.2d 1290 (5th Cir. 1989); *Cantrell v. Great Republic Ins. Co.*, 873 F.2d 1249 (9th Cir. 1989); *Straub v. Western Union Telegraph Co.*, 851 F.2d 1262 (10th Cir. 1988); *Hermann Hosp. v. Meba Medical & Benefits Plan*, 845 F.2d 1286 (5th Cir. 1988).

mistrial based upon alleged improper argument by plaintiff's counsel. The defendants claim that the plaintiff's counsel improperly aroused the passion and prejudice of the jury against the defendants. The plaintiff claims that the jury verdict is the result of the overwhelming evidence of fraud, cover-up, and conspicuously selective memories that was introduced at the trial of the case. We have repeatedly held that in fraud actions "great latitude is allowed in the scope of evidence introduced." *Simmons Mach. Co. v. M & M Brokerage, Inc.*, 409 So.2d 743, 756 (Ala. 1981). The reason for allowing such latitude is that the perpetrator of a fraud is often the sole possessor of the actual knowledge of fraud. *Sessions Co. v. Turner*, 493 So.2d 1387, 1391 (Ala. 1986).

Questions of materiality, relevancy, and remoteness of evidence are matters resting within the discretion of the trial court, whose exercise of that discretion will not be reversed unless it has been grossly abused. *Dorcal, Inc. v. Xerox Corp.*, 398 So.2d 665, 670-71 (Ala. 1981). This discretion extends to argument of counsel. We have said:

> "The control of arguments rests largely in the discretion of the trial court, before whom the argument is made, and who sees and can judge the demeanor of the counsel making the argument, and who can determine whether a prejudicial atmosphere is created by such remarks; therefore, we will not interfere where this discretion is not abused."

Southern Ry. Co. v. Jarvis, 266 Ala. 440 at 446, 97 So.2d 549 (1957), in accord, *Old Southern Life Ins. Co. v. Woodall*, 348 So.2d 1377 (Ala. 1977).

Counsel may state or comment upon all evidence admitted at trial and draw inferences and conclusions from that evidence. *Seaboard Coastline R. R. v. Moore*, 479 So.2d 1131 (Ala. 1985). This Court has established a standard of review on claims for improper argument whereby we will not reverse unless substantial prejudice

has resulted. *Id.*, at 1136. In denying defendants' motion for a JNOV, new trial, and remittitur, the trial court stated: "[T]he court cannot call to mind [nor] have the attorneys for the defendants shown to the court any factor at all that could be construed to indicate bias, passion, prejudice, corruption, or other improper motive or cause on the part of the jury."

We recently affirmed a trial court's refusal to grant a mistrial, under circumstances similar to the present case, in which there was a reference to the wealth of the defendants. We observed that the court heard the remark in context, witnessed the effect upon the jury, and was able to make a better judgment than we were as to whether the remark was improper argument and might have prejudiced the jury. *L. W. Johnson & Assoc., Inc. v. Rivers Construction Co.*, 532 So.2d 618 at 625 (Ala. 1988). We have carefully examined the record in this case and find no error by the trial judge, who had the opportunity to judge the demeanor of counsel and who could determine whether his remarks created a prejudicial atmosphere.

The defendants also claim that the trial court erred in charging the jury. The jury asked: "Are the defendants 'the corp. and Pam' or 'the corp. or Pam?' " The judge replied:

> "THE COURT: Well, for your purposes it doesn't make any difference. I mean the corporation is fully responsible for the acts of its agents, so it dosen't make any difference. I mean, you know, we're concerned—you know, the representations are the representations of the agent. I mean, I don't think I—is that—
>
> "JUROR: That's what we needed to know."

Defendants admit that the trial court correctly instructed the jury that a corporation is responsible for the acts of its agents. We find no error in so instructing the jury.

Defendants contend that the trial court erred in refusing to submit special verdict questions to the jury and in charging the jury as to reckless fraud. Under Rule 49, Ala. R. Civ. P., the use of a special verdict is within the sound discretion of the trial court. After instructing the jury on willful misrepresentation, based on the *Alabama Pattern Jury Instructions*, the trial court charged the jury on the definition of reckless misrepresentation as follows:

> "A reckless misrepresentation which is also actionable [sic]; the law says that if you are reasonably satisfied from the evidence that the defendant misrepresented a material fact recklessly without knowledge of the truth or the falsity thereof and with the intent to induce the plaintiff to act and that the plaintiff acted upon said reckless misrepresentation to his injury, then the defendant is also guilty of a legal fraud under those circumstances.
>
> "If the plaintiff has not proved the case of fraud through either an intentional or a reckless misrepresentation as I just described to you, you would go no further. Your verdict would be for the defendant." [R. 295-96.]

One of the Alabama pattern jury instructions defines "reckless misrepresentation" as follows:

> "If you are reasonably satisfied from the evidence that the defendant misrepresented a material fact recklessly without knowledge of the truth or falsity thereof and with the intent to induce plaintiff to act and that plaintiff acted upon said reckless misrepresentation to his injury, then defendant is guilty of a legal fraud."

Alabama Pattern Jury Instructions (Civil), Instruction 18.02, p. 270.

During jury deliberations, the jury had a question. The trial court asked the foreman: "You want me to define

a reckless misrepresentation?" The foreman replied: "Yes, Sir." To this the trial judge responded:

> "If you are reasonably satisfied from the evidence that the defendants misrepresented a material fact recklessly without knowledge of the truth or falsity and with the intent to induce the plaintiff to act, and the plaintiff did act upon the reckless misrepresentation to his injury, then the defendant is guilty of a legal fraud." [R. 306]

The trial court gave the identical definition of reckless misrepresentation both during his oral charge and after the jury's question. In doing so, he correctly charged the jury.

The defendants also contend that the court's charge on punitive damages in a fraud case constitutes reversible error. The longstanding rule of this Court is as follows:

> "[P]unitive damages may be recovered in a fraud action if the fraudulent misrepresentation was malicious, oppressive, or gross, or made with knowledge of its falsity or so recklessly as to amount to the same thing or was made with the purpose of injuring the plaintiff."

Curry Motor Co. v. Hasty, 505 So.2d 347 (Ala. 1987). See: *Morgan v. South Central Bell Telephone Co.*, 466 So.2d 107 (Ala. 1985).

In the present case, the trial judge instructed the jury in his oral charge as follows:

> "[T]he law says that you are authorized to award punitive damages in a fraud action if it is shown to your reasonable satisfaction from the evidence that the fraud was malicious, oppressive, or gross, or a misrepresentation was made with the knowledge of its falseness or so recklessly done as to amount to

> the same thing and committed with the intent to injure and to defraud." [R. 296-97.]

The jury had a question on the meaning of reckless fraud during its deliberations. The trial court further instructed the jury as follows:

> "I just want to clarify one thing, ladies and gentlemen, I want to clarify this: the definition I just read to you would authorize if the plaintiff proved it, to recover actual damages. With respect to recovering punitive damage, the law says that the fraud must be malicious, oppressive or gross or made with knowledge of the falseness of the representation or so recklessly done as to amount to the same thing and committed with the intent to injure and defraud."

The trial court did not err in charging the jury.

The defendants argue that the trial court erred in denying their motions for directed verdict, judgment notwithstanding the verdict, and a new trial based upon the insufficiency of the evidence or either intentional or reckless fraud. We have carefully reviewed the record in this case. The record supports the decision of the trial judge.

The defendants argue that the award of punitive damages violates the Constitution of Alabama and the Constitution of the United States of America. They argue that the jury verdict of $1,797,588 in punitive damages is based upon only $2,412 in compensatory damages. However, the defendants did not raise any constitutional question prior to filing their motion for judgment notwithstanding the verdict, or, in the alternative, for a new trial or for a remittitur. Although the trial judge, in his order of June 13, 1988, states that the defendants' challenges to the constitutionality of the award of punitive damages "were timely raised and effectively

presented," in fact, these issues were not raised until 29 days after the trial court had entered judgment on the jury's verdict.

It is settled law that constitutional issues must be raised before the trial court in order to be preserved for review upon appeal. *Marion v. Hall*, 429 So.2d 937 (Ala. 1983); *Talley v. A & M Construction Co.*, 284 Ala. 371, 373, 225 So.2d 359, 360 (1969), *cert. denied*, 397 U.S. 995, 90 S.Ct. 1133, 25 L.Ed.2d 402 (1970); *Hicks v. Huggins*, 405 So.2d 1324 (Ala. Civ. App.), *cert. denied*, 405 So.2d 1328 (Ala. 1981). We have declined previously to consider similar issues because "these challenges were not presented for resolution before the trial court and [were] presented for the first time on appeal." *Nationwide Mutual Ins. Co. v. Clay*, 525 So.2d 1339, 1344 (Ala. 1987), *cert. denied*, —— U.S. ——, 109 S. Ct. 863, 102 L.Ed.2d 988 (1989). Thus, the defendants did not preserve their constitutional issues for appeal. However, we would be remiss if we neglected to note that the United States Supreme Court has recently ruled in the case of *Browning-Ferris Industries of Vermont, Inc. v. Kelco Disposal, Inc.*, [No. 88-556, June 26, 1989] —— U.S. —— (1989) that the excessive fines clause of the Eighth Amendment does not apply to punitive damages awards in cases between private parties. In doing so, the Supreme Court upheld an award of $6 million in punitive damages when the compensatory damages were $51,146.

Finally, the defendants claim that the verdict of the trial court was excessive and should be set aside.

With respect to the question of a remittitur, it is within the authority of this Court to order a remittitur, pursuant to *Code of Alabama* (1975), § 12-33-71, if it finds the judgment to be excessive. The rules that govern this Court's review of a verdict claimed to be excessive were set out in *Vest v. Gay*, 275 Ala. 286, 154 So.2d 297 (1963):

> " 'The rules governing our consideration of this question are clear and have been reiterated quite often. We refer to them briefly for emphasis: The verdict of a jury should not be interfered with merely because in the opinion of the court the jury gave too little or too much . . .; and the authority vested in the courts to disturb a verdict of the jury on the ground of excessive damages is one which should be exercised with great caution . . .; where there is no set standard for the admeasurement of the damages but the damages to be awarded are left to the sound discretion of the jury, a remittitur or a new trial should not be ordered on the ground of excessiveness of the jury's verdict except in those cases where the court can clearly see that the verdict has been reached on account of bias, passion, prejudice, corruption, or other improper motive or cause . . .; but where the damages allowed are so excessive as to warrant the belief that the jury must have been misled by some mistaken view of the merits of the case the court may interfere and set the verdict aside . . .; also, where the trial court refuses to grant a new trial because [it] does not believe the verdict to be excessive, the favorable presumption attending the jury's verdict is thereby strengthened. . . .' "

(As quoted in *Black Belt Wood Co., Inc. v. Sessions*, 514 So.2d 1249, at 1264-65 (Ala. 1986).)

The trial court issued an order denying defendants' motion for a remittitur, and in it the trial judge expressly acknowledged that he had carefully considered all of the evidence on all issues. The trial judge noted that a remittitur or new trial is proper "where the court can clearly see that the verdict is tainted by bias, passion, prejudice, corruption, or other improper motive or cause on the part of the jury." The trial judge stated in his order as follows:

"The Court has carefully considered all of the evidence in the case on all issues. The Court has carefully considered the nature and quality of the testimony of all of the witnesses, as well as the demeanor of each witness while testifying. The Court has further reviewed its Charge to the jury on the issue of damages and has found that it correctly instructed the jury on damages. As a part of the charge, the jury was instructed that if they found in favor of the Plaintiff, Edward Menton, and against the Defendants, HealthAmerica and Pamela Merle, that in assessing damages they should take into consideration and give due regard to the enormity of the wrong and the necessity of preventing similar wrongs in the future.

"After a careful review by the Court of the entire trial of the case, including the testimony of all of the witnesses, all of the documentary and demonstrative evidence produced at trial, the Court's observation of all parties and witnesses, and the Court's charge to the jury on damages, the Court is convinced that the jury carefully and conscientiously followed the Court's instructions in assessing damages in the case at $1,800,000.00 and that the award is consistent with the Court's instructions and supported by the evidence.

"This Court finds, after a review of the entire trial, that the central issue presented in the Defendant's motion for remittitur is whether or not the jury verdict of $1,800,000.00 in this case is, in and of itself, evidence of bias, passion, prejudice, corruption or other improper motive or cause. The Court cannot call to mind [nor] have the attorneys for the Defendants shown to the Court any factor at all that could be construed to indicate bias, passion, prejudice, corruption, or other improper motive or cause on the part of the jury. On the contrary, the Court

finds that there was clear and convincing evidence of fraud on the part of the Defendants, HealthAmerica and Pamela Merle, which in the Court's opinion fully justified the jury's verdict.

"The Court finds that the $1,800,00.00 verdict is not excessive and is not the result of bias, passion, prejudice, corruption, or other improper motive or cause."

We have reviewed this order of the trial judge, and we find that he followed the guidelines we have previously adopted to be used by a trial court in reviewing judgments. *Hammond v. City of Gadsden*, 493 So.2d 1374 (Ala. 1986); *Harmon v. Motors Ins. Corp.*, 493 So.2d 1370 (Ala. 1986); *Alabama Farm Bureau Mutual Cas. Ins. Co. v. Griffin*, 493 So.2d 1379 (Ala. 1986). The trial judge applied the principles of law adopted in those cases, held a hearing, and set forth the reasons why he felt that the law did not authorize him to order a remittitur.

We have examined the record in the light of our rules as to remittitur. We are of the opinion that the judgment of the trial court, including the damages award, which the trial court reviewed on motion for JNOV, for a new trial, and for remittitur, is due to be, and it is hereby is, affirmed.

AFFIRMED.

Hornsby, C. J., and Jones, Adams, Steagall, and Kennedy, JJ., concur.

Maddox and Houston, JJ., dissent, with opinion by Houston, J.

HOUSTON, JUSTICE (dissenting).

The second paragraph in Article VI, of the Constitution of the United States, provides:

> "*This Constitution, and the laws of the United States which shall be made in pursuance thereof*; and all treaties made, or which shall be made, under the authority of the United States, shall be *the supreme law of the land; and the judges in every state shall be bound thereby, any thing in the Constitution or laws of any state to the contrary notwithstanding.*" (Emphasis supplied.)

If I were writing on a clean slate, freed from the deference that I do and must give to the opinions of the United States Supreme Court, I could reach the *result* reached by the majority of this Court in this case, on the preemption issue, for I would adopt the "purpose-effect" and "regulation-interpretation" distinctions suggested as an alternative approach to the "relate to" requirement by William J. Kilberg's and Paul D. Inman's article *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514*, 62 Tex.L. Rev. 1313, 1328-30 (1984). However, I have given my solemn oath to uphold the Constitution of the United States, and that includes the second paragraph of Article VI; therefore, I must dissent.

Justice O'Connor, in delivering the opinion for a unanimous Court in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 44-46, 107 S.Ct. 1549, 1551-52 (1987), wrote:

> "In ERISA, Congress set out to
>
> > "'protect . . . participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for

> fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.' § 2, as set forth in 29 U.S.C. § 1001(b).

"ERISA comprehensively regulates, among other things, employee welfare benefit plans that, 'through the purchase of insurance or otherwise,' provide medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability or death. § 3(1), 29 U.S.C. § 1002(1).

"Congress capped off the massive undertaking of ERISA with three provisions relating to the pre-emptive effect of the federal legislation:

> " 'Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . .' § 514(a), as set-forth in 29 U.S.C. § 1144(a) (pre-emption clause).
>
> " '. . . .'

". . . .

" '[T]he question whether a certain state action is pre-empted by federal law is one of congressional intent. " 'The purpose of Congress is the ultimate touchstone.' " ' *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 208, 105 S.Ct. 1904, 1909, 85 L.Ed.2d 206 (1985), quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504, 98 S.Ct. 1185, 1189, 55 L.Ed.2d 443 (1978), quoting *Retail Clerks v. Schermerhorn*, 375 U.S. 96, 103, 84 S.Ct. 219, 222, 11 L.Ed.2d 179 (1963). We have observed in the past that the express pre-emption provisions of ERISA are deliberately expansive, and *designed to 'establish pension plan regulation as exclusively a federal concern.' Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504,

523, 101 S.Ct. 1895, 1906, 68 L.Ed.2d 402 (1981). As we explained in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490 (1983):

> "'The bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected those provisions in favor of the present language, and indicated that section's pre-emptive scope was as broad as its language. See H.R.Conf.Rep. No. 93-1280, p. 383 (1974); S.Conf.Rep. No. 93-1090, p. 383 (1974).'" (Emphasis supplied.)

In Kilberg and Inman's *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514*, 62 Tex.L.Rev. 1313, 1315-16, the following appears:

> "Express preemption provisions such as section 514 must be distinguished from the implied preemption that arises from the supersession inherent in antithetical federal and state commands or from the encroachment of state law into a field occupied by comprehensive federal regulation or interests. To strike down a state law in an implied preemption case, the court must find either a specific conflict between federal and state commands for a clash between zones of sovereign interest. The goal of an implicit preemption analysis should be to accommodate the federal interest with the least possible displacement of state law. *The goals of an express preemption analysis, in contrast, should be to prevent subtle or incremental state encroachment into a field that Congress has chosen expressly to reserve for federal law.* Yet, courts have mistakenly applied preemption doctrines fashioned in implied preemption cases to section 514 cases, in which the issue is

whether the federal law—by its express terms—preempts the state law in question. *Once Congress has declared its express intent to preempt or to save a state law, it has largely obviated judicial inquiry into considerations other than those concerning the text of the preemption provision.*" (Emphasis supplied.)

"[A]ny and all State laws insofar as they may now or hereafter relate to any employee benefit plan," subject to certain exceptions that will be discussed later, is what Congress expressly preempted. 29 U.S.C. § 1144 (a). "The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law. . . ." 29 U.S.C. § 1144(c). Does this preempt a civil action by Menton, who is a "participant" (29 U.S.C. § 1002(7)) and a "party in interest" (29 U.S.C. § 1002 (14)) for an intentional or reckless misrepresentation by HealthAmerica, which is a "party in interest" (29 U.S.C. § 1002 (14)) as to the medical coverage benefits provided by a particular employee benefit plan?

Medical coverage benefits are benefits that "accumulate over a period of time and are payable only upon the occurrence of a contingency outside of the control of [Menton];" therefore, they are "risks that ERISA is intended to address," *Massachusetts v. Morash*, —— U.S. ——, 109 S.Ct. 1668, 1669 (1989). Likewise, the phrase "relate to" has been given its broad commonsense meaning, so that a state law relates to an employee benefit plan "if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines*, 463 U.S. 85, 97, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985); *Pilot Life Ins. Co. v. Dedeaux*, supra. In this case, the representation was made by a party in interest as to an employee benefit plan to a party in interest as to that same employee benefit plan concerning medical benefits payable under that employee

benefit plan. Clearly, the representation related to the employee benefit plan, as "related to" is defined by the United States Supreme Court.

In *Pilot Life Ins. Co. v. Dedeaux*, supra, Dedeaux's complaint contained three counts: " 'tortious breach of contract' "; " 'breach of fiduciary duties': "; and " '*fraud in the inducement.*' " (Emphasis supplied.) 481 U.S. at 43, 107 S.Ct. at 1551. At the close of discovery, Pilot Life moved for summary judgment, arguing ERISA preemption. The district court entered summary judgment; the Court of Appeals for the Fifth Circuit reversed; the United States Supreme Court granted certiorari and reversed the Fifth Circuit and reinstated the summary judgment for Pilot Life. In *Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir. 1987), the Eleventh Circuit Court of Appeals held that Alabama state law claims of bad faith and fraud (which a review of the amended complaint in *Belasco* shows to be remarkably similar to the fraud alleged in the case at issue) of a plaintiff, who was a "participant" and a "party in interest" as to an employee benefit plan against an insurance company that was a "party in interest" as to that employee benefit plan related to the plan and were preempted.

The facts in *Davidian v. Southern California Meat Cutters Union & Food Employees Benefits Fund*, 859 F.2d 134 (9th Cir. 1988), are similar to the facts in the case at issue. Davidian, a "participant" and "party in interest" as to an employee benefit plan, alleged that he was planning to retire and that the plan gave him a choice of one of three benefits programs. A "party in interest" as to the plan described the third option as paying "approximately 80%" of major medical coverage, like plaintiff's prior coverage, but did not inform the plaintiff that, unlike his prior coverage, reimbursement for major medical expenses under the third option was capped at $20,000.00. The plaintiff enrolled in the third option and

subsequently underwent heart surgery. The plan refused to pay plaintiff's medical expenses in excess of $20,000.00. Davidian filed suit against the plan for fraud and deceit. The Ninth Circuit held that Davidian's claims were preempted and addressed Davidian's contention that claims for future benefits, as distinguished from past benefits, are not preempted, as follows:

> "There is no reason for such a distinction based on the purpose of the preemption provisions of the Act. The potential for conflicting and inconsistent state and local regulation of employee benefit plans is as real whether past or future benefits are involved."

859 F.2d at 135.

This Court held that the bad faith refusal to pay insurance benefits under an employee benefit plan by a party in interest as to an employee benefit plan to a party in interest as to that same employee benefit plan did not relate to the plan and was not preempted by ERISA. *Hood v. Prudential Ins. Co. of America*, 460 So.2d 1227 (Ala. 1984). After the United States Supreme Court decided *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985), and *Pilot Life Ins. Co. v. Dedeaux, supra*, we reversed ourselves and held that Hood's bad faith claim was preempted. *Hood v. Prudential Ins. Co. of America*, 522 So.2d 265 (Ala. 1988). Having had our judicial flexibility rendered rather rigid by our federalist system, we have ruled in favor of ERISA preemption of common law causes of action. See, *Landy v. Travelers Insurance Co.*, 530 So.2d 214 (Ala. 1988); *Hood v. Prudential Ins. Co. of America*, 522 So.2d 265 (Ala. 1988); and *Seafarers' Welfare Plan v. Dixon*, 512 So.2d 53 (Ala. 1987).

Justice O'Connor in *Pilot Life*, supra, wrote:

> "The Solicitor General, for the United States as *amicus curiae*, argues that Congress clearly expressed an intent that the civil enforcement provisions of

ERISA § 502(a) be the *exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits*, and that varying state causes of action for claims within the scope of § 502(a) would pose an obstable to the purposes and objectives of Congress. *Brief for United States as Amicus Curiae* 18-19. We agree. The conclusion that § 502(a) was intended to be exclusive is supported, first, by the language and structure of the civil enforcement provisions, and second, by legislative history in which Congress declared that the pre-emptive force of § 502(a) was modeled on the exclusive remedy provided by § 301 of the Labor-Management Relations Act (LMRA), 61 Stat. 156, 29 U.S.C. § 185.

"The civil enforcement scheme of § 502(a) is one of the essential tools for accomplishing the stated purposes of ERISA. The civil enforcement scheme is sandwiched between two other ERISA provisions relevant to enforcement of ERISA and to the processing of a claim for benefits under an employee benefit plan. Section 501, 29 U.S.C. § 1131, authorizes criminal penalties for violations of the reporting and disclosure provisions of ERISA. Section 503, 29 U.S.C. § 1133, requires every employee benefit plan to comply with Department of Labor regulations on giving notice to any participant or beneficiary whose claim for benefits has been denied, and affording a reasonable opportunity for review of the decision denying the claim."

481 U.S. at 52-53, 107 S.Ct. at 1555-1556. (Emphasis supplied.)

In view of this policy, I cannot see how civil actions for bad faith in processing claims for benefits under ERISA plans are preempted and civil actions for misrepresentations made by a "party in interest" to a "party in interest/participant" concerning the coverage under

ERISA plans are not, and, indeed, they have been so pre-empted in most cases since *Pilot Life*, supra. See, i.e., *Pilot Life* (fraud in the inducement); *Belasco* (misrepresentation of benefits payable under an ERISA plan); *Davidian* (misrepresentation of benefits payable under an ERISA plan). I have studied all of the cases cited in the majority opinion, in briefs, and at oral argument by the parties, and I do not believe that an analysis of each case would be helpful to the bench or bar. Contrary to what the majority contends, I believe that the weight of authority of cases decided since *Pilot Life*, supra, supports my conclusion.

Reluctantly, I would hold Menton's claim to be related to the Press Register's employee benefit plan and pre-empted by ERISA on authority of *Shaw v. Delta Air Lines*, supra; *Metropolitan Life Ins. Co. v. Massachusetts*, supra; *Pilot Life Ins. Co. v. Dedeaux*, supra; *Belasco v. W.K.P. Wilson & Sons, Inc.*, supra; and *Davidian v. Southern California Meat Cutters Union & Food Employees Benefits Fund*, supra.

I am not persuaded that civil actions for bad faith or fraud have anything to do with regulation of employee benefit plans or that the purpose for such actions is to affect the terms and conditions of employee benefit plans. However, I believe that this has been decided otherwise by a higher court; and I cannot justify holding that Menton's cause of action does not "relate to" an employee benefit plan in order to save it from pre-emption, when the causes of action asserted in *Pilot Life*, supra, for tortious breach of contract and fraud in the inducement and the causes of action asserted in *Belasco*, supra, for bad faith and fraud were held to "relate to" employee benefit plans and therefore to be preempted. To so hold would be to make a distinction without a difference.

Is Menton's cause of action exempted from preemption under 29 U.S.C. § 1144(b)(2)(A)? That statute reads:

"[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance. . . ."

The trial court indicated that it was not granting HealthAmerica's and Merle's motions for directed verdict, because the HMO statutes and the Alabama "twisting" statute were laws regulating insurance and, under the evidence, could be the basis of Mentam's cause of action. Prior to final judgment, Mentam's complaint did not mention or purport to be brought under either statute.

The HMO statutes did not become effective until May 29, 1986, almost a year after Mentam's cause of action accrued. As a general rule, statutes, except remedial statutes, will not be construed to have retroactive effect unless the language of the statute expressly indicates that the Legislature so intended. *Jones v. Causey*, 445 So.2d 873 (Ala. 1983). There is no expression of legislative intent that the HMO statutes apply to causes of action that accrued prior to the effective date of that legislation. This Court defined remedial statutes in *Stowe v. City of Anniston*, 381 So.2d 26, 29 (Ala. 1980), as "those relating to remedies or modes of procedure, which do not create new rights or take away vested ones." For Mentam's cause of action to be saved from preemption by the HMO statutes, the statutes would have to regulate insurance and give him a new private cause of action. A statute creating a new right, a new cause of action, is clearly substantive in nature and would not be given retroactive application in the absence of a provision indicating a contrary legislative intent. I need not address whether the HMO statutes create a private cause of action, for if they do they will not be given retroactive effect. Therefore, I need not discuss whether the Alabama HMO statutes "regulate insurance," for Mentam's cause of action for misrepresentation is not saved from preemption by the HMO statutes.

The purpose for Chapter 12 ("Trade Practices Law") of Title 27 ("Insurance") is expressed in § 27-12-1 as:

> "The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in the Insurance Regulation Act by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined."

Section 27-12-6 ("Twisting)" provides:

> "*No person* shall make or issue, or cause to be made or issued, any written or oral statement misrepresenting or making misleading incomplete comparisons as to the terms, conditions or benefits contained in any policy for the purpose of inducing, or attempting or tending to induce, the policyholder to lapse, forfeit, surrender, retain, exchange or convert any insurance policy." (Emphasis supplied).

Section 27-1-2(3) defines "person" for the purposes of Title 27 as follows:

> "An individual, insurer, company, association, organization, Lloyd's insurer, society, reciprocal insurer or interinsurance exchange, partnership, syndicate, business trust, corporation and every legal entity."

Section 27-1-2(2) defines "insurer" for the purposes of Title 27 as follows:

> "Every person engaged as indemnitor, surety or contractor in the business of entering into contracts of insurance."

In *Pilot Life*, supra, Dedeaux did not contend that his cause of action for fraud in the inducement was a law that regulated insurance and was thus saved from preemption, so this was not discussed by Justice O'Connor in her opinion. Dedeaux did contend that the cause of action for bad faith did regulate insurance and was saved from preemption by § 514(b)(2)(A). In regard

to this, Justice O'Connor wrote that the Court first took "what guidance was available from a 'common-sense view' of the language of the saving clause itself." 481 U.S. at 48, 107 S.Ct. 1553 (*"any law of any State which regulates insurance"*). "Second," she wrote, "we made use of the case law interpreting the phrase 'business of insurance' under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, in interpreting the saving clause"; and, she noted that in doing so the Court used these criteria:

> " '[*F*]*irst*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.' "

481 U.S. at 49, 107 S.Ct. at 1553.

In applying the "common sense view," Justice O'Connor reasoned that the phrase "regulates insurance" does not support the argument that the Mississippi law of bad faith falls under the saving clause, since the Mississippi Supreme Court, as early as 1915, had recognized that punitive damages were available in a contract case when " 'the act or omission constituting the breach of any [contract, not just an insurance] contract amounts also to the commission of a tort.' "

> "Certainly a common-sense understanding of the phrase 'regulates insurance' does not support the argument that the Mississippi law of bad faith falls under the saving clause. A common-sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but be specifically directed toward that industry. Even though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots

> of this law are firmly planted in the general principles of Mississippi tort and contract law."

481 U.S. at 50, 107 S.Ct. at 1554.

The Alabama "twisting" statute appears to be directed toward the insurance industry. However, since 1907, the Alabama Legislature has provided a civil action for "[m]isrepresentations of a material fact made willfully to deceive, or recklessly without knowledge." § 6-5-101. The Alabama Supreme Court, at least since 1933, has allowed punitive damages to be recovered in such misrepresentation actions, when the misrepresentations were made by the defendant with the intent to defraud the plaintiff. *Cartwright v. Hughes*, 226 Ala. 464, 147 So. 399 (1933). So the roots of misrepresentation were firmly planted in the general principles of Alabama tort law, before the Legislature enacted the "twisting" statute in 1971. Until the post-final judgment amendment of his complaint, Menton had pursued his civil action against HealthAmerica and Merle under this firmly planted general principle of Alabama tort law.

In *Pilot Life*, supra, the United States Supreme Court found that the factors set out in the McCarran-Ferguson Act did not support Dedeaux's assertion that the Mississippi law of bad faith "regulates insurance," for (1) it did not affect a spreading of policyholder risk; (2) "[t]he state common law of bad faith is . . . no more 'integral' to the insurer-insured relationship than any State's general contract law is integral to a contract made in that State." 481 U.S. at 51, 107 S.Ct. at 1555; and (3) "Mississippi's law of bad faith, even if associated with the insurance industry, has developed from general principles of tort and contract law available in any Mississippi breach of contract case." 481 U.S. at 51, 107 S.Ct. at 1555. The Court then held "the Mississippi common law of bad faith at most meets one of the three criteria used to identify the 'business of insurance' under

the McCarran-Ferguson Act, and used in *Metropolitan Life* to identify laws that 'regulat[e] insurance' under the saving clause."

I do not find that the "twisting" statute affected a spreading of the risks among policyholders; or that the "twisting" statute is more integral to the insurer-insured relationship than Alabama's misrepresentation statute, as developed from general principles of tort law; or that the statute in its definition of "person" and "insurer" is limited to entities in the insurance business.[2] Therefore, using Justice O'Connor's criteria for determining when a state law "regulates insurance" and is therefore saved from ERISA preemption, I would find that the "twisting" statute does not save Menton's claim from preemption. By this, I do not mean to imply that Alabama's "twisting" statute affords a private cause of action to Menton.[3] I need not reach this issue.

A unanimous United States Supreme Court in *Pilot Life*, supra, held that Dedeaux's state law claims, includ-

---

[2] Alabama Code 1975, § 27-12-24, provides:

> "No *insurer* shall, without just cause, refuse to pay or settle claims arising under coverages provided by its policies in this state. . . ." (Emphasis supplied.)

From the pleadings in *Belasco v. W.K.P. Wilson & Son, Inc.*, supra, we cannot determine whether this Code section, which is contained in Chapter 12 ("Trade Practices Law") of Title 27 ("Insurance") was relied on by *Belasco* as a law regulating insurance.

> "Plaintiffs argue that the Alabama law of bad faith, which forms the basis of one of their claims, is a 'law . . . which regulates insurance,' 29 U.S.C. § 1144(b)(2)(A), and therefore falls under the saving clause. However, the Alabama law of bad faith appears to us to have the same roots 'in the general principles of . . . tort and contract law' as was the case in *Dedeaux*."

833 F.2d at 281.

[3] In *Farlow v. Union Cent. Life Ins. Co.*, 874 F.2d 791 (11th Cir. 1989), the Eleventh Circuit Court of Appeals held that the Alabama twisting statute does not create a private cause of action.

ing bad faith and fraud in the inducement, were preempted, even though Dedeaux elected not to assert any of the remedies that would be available under ERISA. Menton elected not to assert any of the remedies that would be available to him under ERISA, i.e., to clarify and enforce his rights under the terms of the plan as represented to him, and to obtain equitable relief (reformation of the health insurance contract to remove the time limitation on physical therapy and orthopedic appliances benefits), etc. 29 U.S.C. § 1132(a). These benefits and an award of attorney fees could have been available to Menton under ERISA, whether he sued in federal or in state court, if he had prevailed on his ERISA claim. *Pilot Life*, 481 U.S. at 53, 107 S.Ct. at 1556. Therefore, ERISA did not deny Menton a remedy. At the conclusion of *Pilot Life*, 481 U.S. at 57, 107 S.Ct. at 1558, Justice O'Connor wrote:

> "*Metropolitan Life* [*Ins. Co. v. Massachusetts*, supra], did not involve a state law that conflicted with a substantive provision of ERISA. Therefore the Court's general observation—that state laws related to ERISA may also fall under the saving clause —was not focused on any particular relationship or conflict between a substantive provision of ERISA and a state law. In particular, the Court had no occasion to consider in *Metropolitan Life* the question raised in the present case: whether Congress might clearly express, through the structure and legislative history of a particular substantive provision of ERISA, an intention that the federal remedy provided by that provision displace state causes of action. . . .
>
> "Considering the common-sense understanding of the saving clause, the McCarran-Ferguson Act factors defining the business of insurance, and, most importantly, the clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive,

> we conclude that Dedeaux's state law suit asserting improper processing of a claim for benefits under an ERISA-regulated plan is not saved by § 514(b)(2)(A), and therefore is pre-empted by § 514(a)."

This action was filed while *Hood v. Prudential Ins. Co. of America*, supra (*Hood I*), was the law. Prior to final judgment in this case, the United States Supreme Court decided *Pilot Life*, supra, and we decided *Seafarers' Welfare Plan v. Dixon*, supra. However, it was after final judgment in this case that this Court reversed *Hood v. Prudential Ins. Co. of America*, supra (*Hood II*) and decided *Landy v. Travelers Insurance Co., supra.* Therefore, I would reverse the judgment of the trial court; however, rather than rendering judgment or remanding with instructions that the trial court grant Health-America and Merle's motion for JNOV, I would reverse and remand and afford Menton the opportunity to amend to state a claim under ERISA.

At the time this complaint was filed, Menton had every reason to believe, every reason to predict, that his state law cause of action asserting misrepresentation of coverage afforded by a health insurance plan would not be preempted by ERISA. See *Hood I.* During the course of this litigation in the circuit court and during this appeal, the rules were changed. This Court could not and did not predict this. See *Hood I.*

I, as a member of the Supreme Court of Alabama, will not thwart an opportunity for a remedy for one whose right to a particular remedy was foreclosed only by his astute attorneys' not being able to guess how Justices would rule. It seems appropriate and altogether just to invoke equitable relief, which is afforded by 29 U.S.C. § 1132(a)(3), to one whose civil cause of action was foreclosed by an expansion of the ERISA preemption after that cause of action had accrued and after an action to enforce it had been filed. See, *Culberson v. Bankers Life Co.*, 541 So.2d 480 (Ala. 1989).

I would reverse and remand to permit Menton to amend and proceed with a cause of action under ERISA, 29 U.S.C. § 1132(a). Therefore, I dissent.

Maddox, J., concurs.

APPENDIX B

Mailing Address: Telephone: 261-4609
P.O. Box 157
Montgomery, Alabama 36101

OFFICE OF
CLERK OF THE SUPREME COURT
STATE OF ALABAMA
MONTGOMERY

Re: 87-1100

HEALTH AMERICA AND PAMELA MERLE
Appellant

vs.

EDWARD MENTON
Appellee

You are hereby notified that the following indicated action was taken in the above cause by the Supreme Court today:

——— Appeal docketed. Future correspondence should refer to the above number.

——— Court Reporter granted additional time to file reporter's transcript to and including

——— Clerk/Register granted additional time to file clerk's record/record on appeal to and including

——— Appell———granted 7 additional days to file briefs to and including

——— Appellant(s) granted 7 additional days to file reply briefs to and including

——— Record of Appeal filed

——— Appendix Filed

——— Submitted on Briefs

——— Petition for Writ of Certiorari denied. No opinion.

xxxx

——— Application for rehearing overruled. No opinion written on rehearing.

——— Permission to file amicus briefs granted

———

9/15/89
bsa

/s/ Robert G. Esdale
ROBERT G. ESDALE
Clerk
Supreme Court of Alabama

APPENDIX C

IN THE CIRCUIT COURT
OF MOBILE COUNTY, ALABAMA

Civil Action No. CV-86-003049

EDWARD MENTON,
Plaintiff,

vs.

HEALTH AMERICA and PAMELA MERLE,
Defendants.

ORDER

[Filed June 13, 1988]

On the 18th day of May, 1988, came to be heard Defendants' Motion for Judgement Notwithstanding the Verdict or, In the Alternative, for New Trial or, In the Alternative, for Remittitur. Having considered the motions; the pleadings and other papers on file herein, the evidence adduced at trial and objections and proceedings in the course of the trial; the case law and other authority cited by all parties either pretrial, during trial, or post trial; and the argument of counsel, it is ORDERED, ADJUDGED, and DECREED as follows:

1.(a) That Defendants' motion for judgement notwithstanding the verdict is due to be and hereby is DENIED;

(b) The Defendants' motion for new trial is due to be and hereby is DENIED;

(c) That Defendants' motion for remittitur is due to be and hereby is DENIED.

2. In connection with all of Defendants' motions, the Court has considered Defendants' claims tha the imposition of punitive damages, both generally under Alabama law and specifically in the amount and as returned by the jury under the facts of this case, is unconstitutional under the Alabama as well as the United States Constitutions (particularly, the Due Process Clause of the 5th Amendment; the Due Process, Equal Protection, and Privileges and Immunities Clauses of the 14th Amendment; the Excessive Fines Clause of the 8th Amendment; the Contracts Clause and prohibition of Ex Post Facto laws of Article I, Section 10, Clause 1). Although these arguments were timely raised and effectively presented, the Court is unpersuaded by such arguments and therefore holds that the imposition of punitive damages, both generally under Alabama law and specifically in the amount as returned by the jury under the facts of this case, is constitutional under both the state and federal constitutions.

3. With respect to Defendants' Motion for a Remittitur, Alabama Law is that a remittitur or new trial should not be ordered on the grounds of excessiveness of the jury's verdict except where the court can clearly see that the verdict is tainted by bias, passion, prejudice, corruption, or other improper motive or cause on the part of the jury.

The Court has carefully considered all of the evidence in the case on all issues. The Court has carefully considered the nature and quality of the testimony of all of the witnesses, as well as the demeanor of each witness while testifying. The Court has further reviewed its Charge to the jury on the issue of damages and has found that it correctly instructed the jury on damages. As a part of the charge, the jury was instructed that if they found in favor of the Plaintiff, Edward Menton, and against the Defendants, Health America and Pamela Merle, that in assessing damages they should take into consideration

and give due regard to the enormity of the wrong and the necessity of preventing similar wrongs in the future.

After a careful review by the Court of the entire trial of the case, including the testimony of all of the witnesses, all of the documentary and demonstrative evidence produced at trial, the Court's observation of all parties and witnesses, and the Court's Carge to the jury on damages, the Court is convinced that the jury carefully and conscientiously follows the Court's instructions is assessing damages in the case at $1,800,000.00, and that the award is consistent with the Court's instructions and supported by the evidence.

The Court finds, after a review of the entire trial, that the central issue presented in the Defendants' Motion for Remittitur is whether or not the jury verdict of $1,800,000.00 in this case is in and of itself evidence of bias, passion, prejudice, corruption or other improper motive or cause. The Court cannot call to mind or have the attorneys for the Defendants shown to the Court any factor at all that could be construed to indicate bias, passion, prejudice, corruption or other improper motive or cause on the part of the jury. On the contrary, the Court finds that there was clear and convincing evidence of fraud on the part of the Defendants, Health America and Pamela Merle, which in the Court's opinion fully justified the jury's verdict.

The Court finds that the $1,800,000.00 verdict is not excessive and is not the result of bias, passion, prejudice, corruption, or other improper motive or cause.

DONE and ORDERED this 13th day of June, 1988.

/s/ Braxton L. Kittrell
BRAXTON L. KITTRELL
Judge
Circuit Court of Mobile County

APPENDIX D

FEDERAL STATUTORY AND CONSTITUTIONAL PROVISIONS

SUBTITLE A—GENERAL PROVISIONS

§ 1001. Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce and the Federal taxing power

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current min-

SUBTITLE B—REGULATORY PROVISIONS

Part I—Reporting and Disclosure

Cross References

Criminal penalties under this part, see section 1132 of this title.

§ 1021. Duty of disclosure and reporting

(a) Summary plan description and information to be furnished to participants and beneciaries

The administrator of each employee benefit plan shall cause to be furnished in accordance with section 1024(b) of this title to each participant covered under the plan and to each beneficiary who is receiving benefits under the plan—

(1) a summary plan description described in section 1022(a)(1) of this title; and

(2) the information described in section 1024(b)(3) and 1025(a) and (c) of this title.

* * * *

§ 1022. Plan description and summary plan description

(a)(1) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in setcion 1024(b) of this title. The summary plan description shall include the information described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such particpnats and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated to be understood

by the average plan participant and shall be furnished in accordance with section 1024(b)(1) of this title.

(2) A plan description (containing the information required by subsection (b) of this section) of any employee benefit plan shall be prepared on forms prescribed by the Secretary, and shall be filed with the Secretary as required by section 1024(a)(1) of this title. Any material modification in the terms of the plan and any change in the information described in subsection (b) of this section shall be filed in accordance with section 1024(a)(1)(D) of this title.

(b) The plan description and summary plan description shall contain the following information: The name and type of administration of the plan; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles, and addresses of any trustee or trustees (if they are persons different from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirement respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 1133 of this title).

(Pub. L. 93-406, Title I, § 102, Sept. 2, 1974, 88 Stat. 841.)

§ 1024. Filing and furnishing of information

* * * *

(b) Publication of summary plan description and annual report to participants and beneficiaries of plan

Publication of the summary plan descriptions and annual reports shall be made to participants and beneficiaries of the particular plan as follows:

(1) The administrator shall furnish to each participant, and each beneficiary receiving benefits under the plan, a copy of the summary, plan description, and all modifications and changes referred to in section 1022 (a) (1) of this title—

(A) within 90 days after he becomes a participant, or (in the case of a beneficiary) within 90 days after he first receives benefits, or

(B) if later, within 120 days after the plan becomes subject to this part.

The administrator shall furnish to each participant, and each beneficiary receiving benefits under the plan, every fifth year after the plan becomes subject to this part an updated summary plan description described in section 1022 of this title which integrates all plan amendments made within such five-year period, except that in a case where no amendments have been made to a plan during such five-year period this sentence shall not apply. Notwithstanding the foregoing, the administrator shall furnish to each participant, and to each beneficiary receiving benefits under the plan, the summary plan description described in section 1022 of this title every tenth year after the plan becomes subject to this part. If there is a modification or change described in section 1022(a) (1) of this title, a summary description of such modification or charge shall be furnished not later than 210 days after the end of the plan year in which the change is adopted to each participant, and to each beneficiary who is receiving benefits under the plan.

(2) The administrator shall make copies of the plan description and the latest annual report and the bargaining agreement, trust agreement, contract, or other instruments under which the plan was established or is operated available for examination by any plan participant or beneficiary in the principal office of the administration and in such other places as may be necessary to make available all pertinent information to all participants (including such places as the Secretary may prescribe by regulations).

(3) Within 210 days after the close of the fiscal year of the plan, the administrator shall furnish to each participant, and to each beneficiary receiving benefits under the plan, a copy of the statements and schedules, for such fiscal year, described in subparagraph (A) and (B) of section 1023(b)(3) of this title and such other material (including the percentage determined under section 1023(d)(11) of this title) as is necessary to fairly summarize the latest annual report.

(4) The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated. The administrator may make a reasonable charge to cover the cost of furnishing such complete copies. The Secretary may by regulation prescribe the maximum amount which will constitute a reasonable charge under the preceding sentence.

* * * *

Part 4—Fiduciary Responsibility

§ 1101. Coverage

(a) This part shall apply to any employee benefit plan described in section 1003(a) of this title (and not exempted under section 1003(b) of this title), other than—

(1) a plan which is unfunded and is maintained by an employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees; or

(2) any agreement described in section 736 of Title 26, which provides payments to a retired partner or deceased partner or a deceased partner's successor in interest.

* * * *

§ 1104. Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses unless

under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions this subchapter or subchapter III of this chapter.

* * * *

§ 1109. Liability for breach of fiduciary duty

(a) Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary. A fiduciary may also be removed for a violation of section 1111 of this title.

(b) No fiduciary shall be liable with respect to a breach of fiduciary duty under this subchapter if such breach was committed before he became a fiduciary or after he ceased to be a fiduciary.

(Pub.L. 93-406, Title I, § 409, Sept. 2, 1974, 88 Stat. 886.)

Part 5—Administration and Enforcement

§ 1131. Criminal penalties

Any person who willfully violates any provision of part 1 of this subtitle, or any regulation or order issued under any such provision, shall upon conviction be fined not more than $5,000 or imprisoned not more than one year, or both; except that in the case of such violation by a person not an individual, the fine imposed upon such person shall be a fine not exceeding $100,000.

(Pub.L. 93-406, Title I, § 501, Sept. 2, 1974, 88 Stat. 891.)

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or

(B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as therwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter; or

(6) by the Secretary to collect any civil penalty under subsection (i) of this section.

* * * *

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 1166 of this title with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

(2) The Secretary may assess a civil penalty of up to $1,000 a day from the date of a plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 1021(b)(4) of this title. For purposes of this paragraph, an annual report that has been rejected under section 1024(a)(4) of this title for failure to provide material information shall not be treated as having been filed with the Secretary.

* * * *

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

* * * *

(2) (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * * *

(5) (A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

* * * *

(7) Subsection (a) of this section shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title).

* * * *

§ 1012. Regulation by State law; Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State

for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the busines of insurance to the extent that such business is not regulated by State law.

Mar. 9, 1945, c. 20, § 2, 59 Stat. 34; July 25, 1947, c. 326, 61 Stat. 448.

AMENDMENT XIV—CITIZENSHIP; PRIVILEGES AND IMMUNITES; DUE PROCESS; EQUAL PROTECTON; APPORTIONMENT OF REPRESENTATION; DISQUALIFICATION OF OFFICERS; PUBLIC DEBT; ENFORCEMENT

Materials for the Citizenship and Privileges and Immunities Clauses of Section 1 are set out in this volume. See the following three volumes for materials pertaining to the Due Process and Equal Protection Clauses of that section and Section 2 to 5.

Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

* * * *

ARTICLE VI—DEBTS VALIDATED—SUPREME LAW OF LAND—OATH OF OFFICE

Cl. 2. Supreme Law of Land.

* * * *

This Constitution, and the Laws of the United States which shall be made in Pursuant thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

* * * *

APPENDIX E

STATE STATUTES

§ 27-12-6. "Twisting."

No person shall make or issue, or cause to be made or issued, any written or oral statement misrepresenting or making misleading incomplete comparisons as to the terms, conditions or benefits contained in any policy for the purpose of inducing, or attempting or tending to induce, the policyholder to lapse, forfeit, surrender, retain, exchange or convert any insurance policy. (Acts 1971, No. 407, p. 707, § 232.)

Supreme Court, U.S.
FILED
JAN 17 1990
JOSEPH F. SPANIOL, JR.
CLERK

No. 89-939

In The

Supreme Court of the United States

October Term, 1989

HEALTHAMERICA AND PAMELA MERLE,

Petitioners,

v.

EDWARD MENTON,

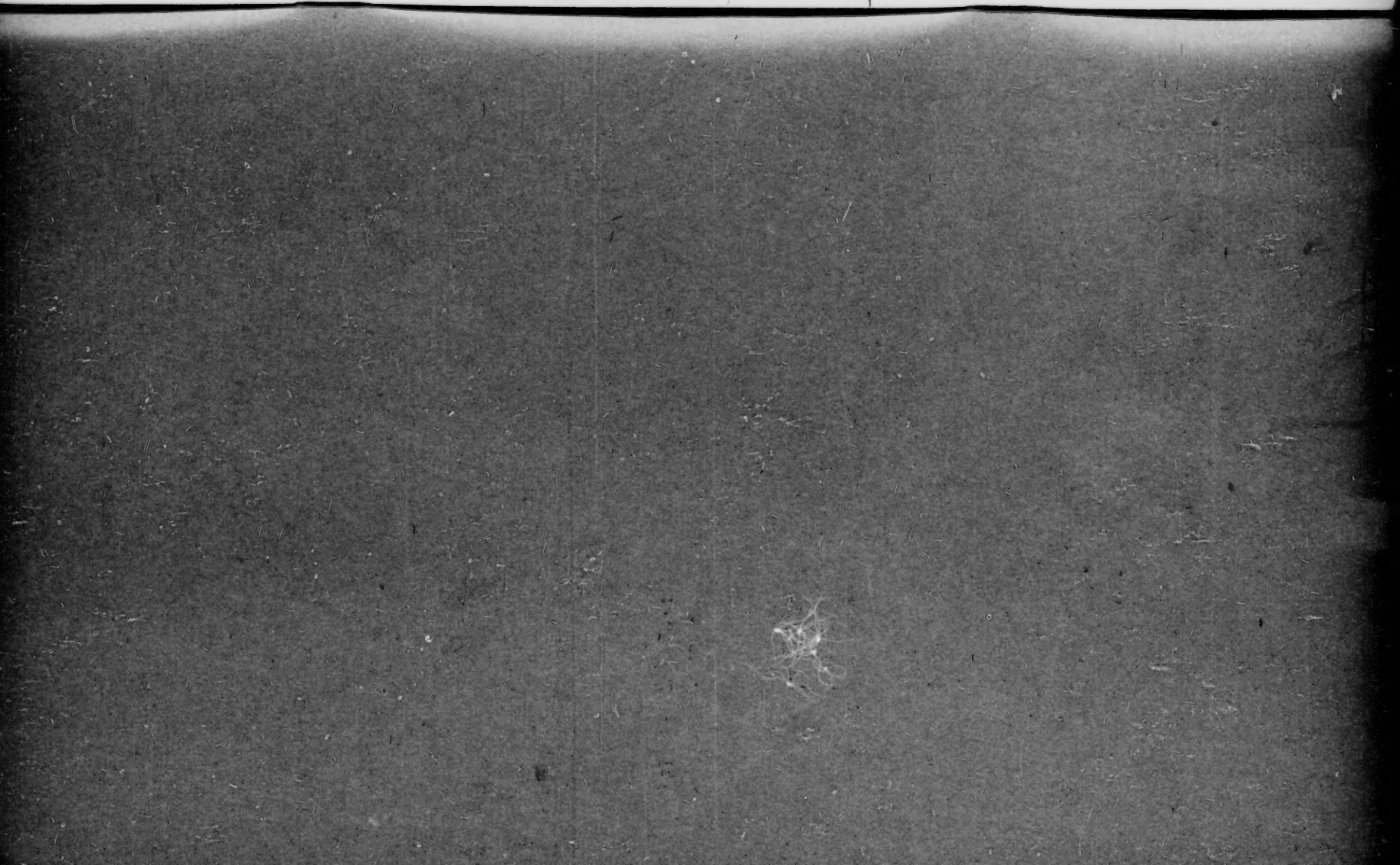
Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF ALABAMA

RESPONDENT'S BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether a state common law action for fraud "relates to" an employee benefit plan within the meaning of ERISA's preemption clause where the plaintiff alleges that the defendants fraudulently induced him to drop his existing medical insurance and to join defendants' health plan?

2. Whether an Alabama insurance trade practices law, which prohibits any person from making false or misleading representations to induce policyholders to drop or change insurance coverage, is a law which "regulates insurance" within the meaning of ERISA's savings clause?

3. Whether a punitive damage award of $1,797,588.00 for reprehensible, fraudulent conduct, which personally exposed the respondent to potentially "hundreds of thousands of dollars" of unexpected medical bills, violates the Due Process Clause of the Fourteenth Amendment, where the amount of the award was subject to an "extensive post-trial evidentiary hearing", and to searching *de novo* review by both the trial and appellate courts?

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No. 89-939

In The

Supreme Court of the United States

October Term, 1989

HEALTHAMERICA AND PAMELA MERKLE,

Petitioners,

v.

EDWARD MENTON,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF ALABAMA

RESPONDENT'S BRIEF IN OPPOSITION

STATEMENT OF THE CASE

As set forth in the July 21, 1989 Opinion of the Alabama Supreme Court (hereinafter "Opinion"), respondent, Edward Menton, was employed as city editor for the *Mobile Press Register* newspaper ("Press Register"). As part of his employment, Mr. Menton was provided medical insurance coverage through the Connecticut General Insurance Company ("Connecticut General"). The Press Register paid 50-60% of the premiums for this insurance and the balance was deducted from Mr. Menton's salary.

Mr. Menton had a son, Jacob, who suffered from a form of cerebral palsy which affected his ability to walk.

To walk normally, Jacob required regular physical therapy treatments, leg braces, crutches, walkers, and other orthopaedic appliances. Pursuant to its policy, Connecticut General paid eighty percent of the costs for Jacob's surgeries, physical therapy, and orthopaedic appliances.

In June, 1985 the Press Register announced "an alternative medical benefit selection", which allowed qualified employees either to keep the Connecticut General insurance or to enroll in one of two health maintenance organizations, Prime Health and petitioner, HealthAmerica. The announcement stated: "Prime Health, Health America [sic] and Connecticut General will be offered to you as a multiple choice option; permitting each employee to continue his or her current health benefits program or to select either of the HMOs for your health care needs." Qualified employees could elect to change coverage during the month of June, 1985 without suffering an interruption of benefits.

With the assistance of David Parker, the assistant general manager of the Press Register, HealthAmerica and Prime Health distributed information about their plans, including a summary of benefits, to the Press Register employees. Because HealthAmerica's list of health care providers included both of Jacob's physicians, Mr. Menton considered joining HealthAmerica's plan, *if HealthAmerica's coverage of Jacob's medical and therapeutic expenses was better than Connecticut General's.* The summary of benefits, however, did not indicate whether HealthAmerica provided coverage for long-term physical therapy and orthopaedic appliances.

Mr. Menton asked Parker whether HealthAmerica provided coverage for Jacob's medical and therapeutic

expenses. Parker could not answer Mr. Menton's question, but suggested that Mr. Menton ask the HealthAmerica representative who was scheduled to hold an informational presentation at the Press Register. The purpose of the presentation was to enable both HealthAmerica and Prime Health "to specifically outline their plan[s]" and to answer specific questions from Press Register employees about coverage. Petitioner, Pamela Merle, presided over this meeting on behalf of HealthAmerica.

Mr. Menton attended Merle's presentation for the sole purpose of determining whether HealthAmerica's plan provided more than eighty percent coverage for Jacob's medical and therapeutic expenses. During the presentation, Press Register employees were repeatedly told that the coverage provided by HealthAmerica and Prime Health was "the same or better" than the Connecticut General coverage. In addition, HealthAmerica distributed a pamphlet which stated that HealthAmerica's plan provided "[m]ore benefits, fewer limitations and no financial surprises" and had "generally no time or dollar limits on coverage".

After the presentation, Mr. Menton asked Merle specific questions about HealthAmerica's coverage of Jacob's medical and therapeutic expenses. He explained Jacob's medical history and his need for extensive, long-term physical therapy and orthopaedic appliances. In response to a direct question from Mr. Menton, Merle informed Mr. Menton that Jacob's medical and therapeutic expenses would be "covered 100% by HealthAmerica." Merle gave no suggestion or hint that physical therapy benefits would be limited in any way.

In reliance upon Merle's representations, Mr. Menton dropped his Connecticut General coverage and enrolled

in HealthAmerica's plan. After enrolling, Mr. Menton received a schedule of benefits in the mail. On reviewing the schedule, Mr. Menton noticed that "short-term" outpatient services for physical therapy were apparently covered for only two months and none of the expenses for Jacob's crutches, braces and walker were covered. At the suggestion of David Parker, who witnessed Merle's representations at the informational meeting, Mr. Menton contacted Merle about the meaning of the limitation contained in the schedule of benefits. Merle told Mr. Menton that HealthAmerica's plan indeed covered only two months of Jacob's physical therapy and *none* of the expenses for orthopaedic appliances. Merle also admitted to Mr. Menton that she had misrepresented the coverage.

Thereafter, Mr. Menton attempted to get HealthAmerica to provide the coverage he had been promised when he dropped his Connecticut General insurance. Mr. Menton was told that his problem would have to be presented to a board of doctors to determine whether the physical therapy benefits could be extended. After several months and numerous dealings, HealthAmerica eventually offered to extend coverage for Jacob's physical therapy for an additional sixty days, but refused to provide coverage beyond that because Mr. Menton's claim was "outside [the] benefit plan" and "could certainly involve hundreds of thousands of dollars . . . ." Even with the extension,[1] HealthAmerica intentionally exposed Mr. Menton to potentially "hundreds of thousands of dollars" of uncovered medical bills and gave no thought to the fact that Jacob might be deprived of needed treatment as a result.

---

[1] HealthAmerica never paid any of the bills incurred during the additional sixty day period.

Despite Merle's previous admission, petitioners steadfastly denied that Merle misrepresented the coverage to Mr. Menton. It was later revealed that Merle had confessed making the misrepresentation during an internal investigation of Mr. Menton's claim. At the subsequent trial, the jury quite clearly concluded that petitioners lied to Mr. Menton during his attempts to resolve the matter and that Merle and HealthAmerica's executive vice president testified falsely under oath.

Mr. Menton filed the instant action against petitioners alleging a state common law action for fraudulent misrepresentation, asserting that petitioners willfully or recklessly induced him to drop his Connecticut General insurance and to elect the petitioners' coverage. Petitioners did not seek to remove this action to federal district court on the basis of ERISA, nor did they allege the failure to exhaust grievance procedures under HealthAmerica's plan as a defense. Instead, petitioners pleaded the general issue and, by amended answer filed *two days* before trial and motion for summary judgment filed barely *a month* before trial, preemption by the Employee Retirement Income Security Act of 1974 ("ERISA"). 29 U.S.C. §§ 1001 *et seq.*

The trial court determined that Mr. Menton's claim was "saved" from preemption by the Alabama "twisting" statute, Ala. Code § 27-12-6, an Alabama Insurance Trade Practices Law which expressly forbids the petitioners' conduct. See, Pet. at 63a. The trial court submitted the case to the jury with instructions on Alabama civil actions for misrepresentation, without reference to the twisting statute. The jury returned a verdict in favor of Mr. Menton. After final judgment, Mr. Menton filed a motion to amend his complaint to conform to the evidence, alleging

a violation of Ala. Code § 27-12-6, i.e., the "twisting" statute. Petitioners' objection to this was overruled, as was their motion for a judgment notwithstanding the verdict and new trial.

On appeal, the Alabama Supreme Court affirmed the judgment of the trial court. The Alabama Supreme Court held that Mr. Menton's fraud action does not "relate to" a benefit plan within the meaning of ERISA's preemption clause. Opinion, Pet. at 8a-15a. The court also held that Mr. Menton's claim is excepted from preemption by ERISA's insurance savings clause because his claim was based upon a state law, the twisting statute, which "regulates insurance". Pet. at 16a. The Alabama Supreme Court refused to review petitioners' constitutional challenges because such issues were not timely raised in the trial court. Pet. at 25a. Following the Alabama Supreme Court's denial of their application for rehearing, petitioners sought a stay of the judgment from Circuit Justice Kennedy, who granted the stay on October 3, 1989 pending this Court's action on the instant petition.

SUMMARY OF ARGUMENT

The Alabama Supreme Court's opinion involves the dual interpretation of ERISA's preemption and savings clauses. Both aspects of the court's opinion are fully consistent with this Court's ERISA decisions. While decisions rendered by the Ninth and Eleventh Circuits conflict with the Alabama Supreme Court's opinion with respect to ERISA preemption, these decisions do not conflict with that portion of the court's opinion which concerns ERISA's savings clause. Hence, the decisions rendered by the Ninth and Eleventh Circuits do not wholly conflict with the court's opinion.

With regard to the court's holding that the twisting statute is saved from ERISA preemption, the court's opinion appears on its surface to conflict with a decision rendered by the Fourth Circuit Court of Appeals. The Fourth Circuit held that a state trade practices law does not "regulate insurance". However, a closer examination reveals that the Fourth Circuit failed to consider this Court's previous ERISA and McCarran-Ferguson decisions which plainly establish that state trade practices laws are indeed laws which "regulate insurance". The stated purpose of Alabama's twisting statute is to "regulate trade practices in the business of insurance". Since the Alabama Supreme Court's decision on the "savings" issue is consistent with this Court's previous decisions, this Court need not grant review to decide this issue.

Petitioners failed to timely raise both the due process challenges and the potential applicability of ERISA's fiduciary and disclosure requirement in the courts below. Consequently, neither of the courts below considered or resolved these issues. Due to the absence of a properly developed record with respect to these important issues, this Court should deny review.

REASONS FOR DENYING THE WRIT

I. THIS COURT SHOULD NOT GRANT REVIEW TO DECIDE WHETHER ERISA PREEMPTS A CLAIM FOR FRAUDULENTLY INDUCING AN EMPLOYEE TO CHANGE HIS HEALTH COVERAGE.

The Alabama Supreme Court's decision is entirely consistent with the decisions of this Court. In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), this Court, in an unanimous decision, observed that laws

which regulate the manner in which insurance is sold do not "relate to" benefit plans:

> "Appellants assert that state laws that directly regulate the insurer, and laws that regulate such matters as the way in which insurance may be sold, are traditional laws subject to the [savings] clause, while laws that regulate the substantive terms of insurance contracts are recent innovations more properly seen as health laws rather than as insurance laws, which § 514(b)(2)(A) does not save. *This distinction reads the savings clause out of ERISA entirely, because laws that regulate only the insurer, or the way in which it may sell insurance, do not 'relate to' benefit plans in the first instance.* Because they would not be preempted by § 514(a), they do not need to be 'saved' by § 514(b)(2)(A) . . . Appellants' construction, in our view, violates the plain meaning of the statutory language and renders redundant both the savings clause it is construing, as well as the deemer clause which proceeds it, and accordingly has little to recommend it."

Id. at 741. Because Mr. Menton's action was based on the twisting statute (see, Pet. at 63a), which specifically regulates the activities of insurance companies in selling insurance and the activities of other entities offering policyholders an alternative to insurance, Mr. Menton's claim does not "relate to" HealthAmerica's plan in the first instance. Thus, the Alabama Supreme Court's decision is consistent with the plain holding of this Court in *Metropolitan Life.*

Despite petitioners' assertion to the contrary (Pet. at 10-11), the Alabama Supreme Court correctly concluded that this Court did not address this issue in *Pilot Life Ins.*

Co. v. Dedeaux, 481 U.S. 41 (1987).[2] In fact, this Court expressly noted that there was "no dispute" that Dedeaux's claims were embraced by ERISA's preemption clause; the only dispute concerned whether his claims were "saved" from preemption. *Id.* at 47. Since *Pilot Life* does not address an action alleging fraudulent inducement *to join an employee benefit plan*, the Alabama Supreme Court's decision is hardly inconsistent therewith.

It is extremely important to note that the basis of Mr. Menton's action concerns the fact that petitioners fraudulently *induced* him to drop his health insurance and opt for HealthAmerica's plan. Opinion, Pet at 8a. Mr. Menton's action, therefore, concerns matters *external* to HealthAmerica's plan and acts *preliminary* to his joining the plan. His action claims damages for being ***induced*** to drop his Connecticut General coverage. It is for this reason, as petitioners so correctly pointed out in the court below, that Mr. Menton's actual damages are calculated by reference to the benefits he would have received if he had kept his Connecticut General coverage. In other words, Mr. Menton's claim concerns the destruction of his old plan, not the confection of the new. For this reason, Mr. Menton's fraud action does not "relate to" HealthAmerica's plan. Opinion, Pet. at 6a.

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[2] The Alabama Supreme Court noted: "Although the complaint in *Pilot Life* contained a count for 'fraud in the inducement', the opinion makes it unmistakably clear that the only claims [Dedeaux] pursued were claims seeking damages for improperly processing his claims for benefits under an ERISA-regulated plan." Opinion, Pet. at 7a.

Petitioners assert that Mr. Menton's fraud action "is concerned with and arises out of the *administration* of an ongoing ERISA benefit plan" and that Merle's misrepresentation "occurred during the process of *explaining coverage and options* under an existing welfare benefit plan". Pet. at 10 & 13 (emphasis added). These assertions clearly mischaracterize the nature of petitioners' conduct. Petitioners were not engaged in the "administration" of an employee benefit plan and were not "explaining coverage and options". Rather, petitioners were engaged in the *solicitation* of membership for their plan. Merle's very purpose for being at the Press Register was to induce employees to drop their existing medical insurance in favor of HealthAmerica's purportedly better, less expensive medical plan.[3]

In reaching its decision, the Alabama Supreme Court relied upon the Court's holding in *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1987), which was decided two months after *Pilot Life*. Opinion, Pet. at 8a-9a. In *Fort Halifax*, the Court held that a Maine statute requiring employers to make one-time severance payments to employees when a plant closed was not preempted by ERISA. The Court noted that the preemption clause expressly states that state laws are superseded to the extent they "relate to any employee benefit plan." The Court stated that the preemption clause "does not refer to state laws relating to 'employee benefits', but to state laws relating to 'employee benefit *plans*.' " *Id.* at 7 (emphasis in original). "Given the basic difference

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[3] These activities are subject to substantial state regulation which is expressly saved from preemption. See Argument II, infra.

between a 'benefit' and a 'plan', Congress' choice of language is significant in its pre-emption of only the latter." *Id.* at 8. The Alabama Supreme Court concluded that the distinction drawn by this Court between laws which relate to employee benefit *plans* and laws which simply relate to employee *benefits* precludes the preemption of Mr. Menton's fraud action. Opinion at 9a. At best, Mr. Menton's action concerns only employee benefits – and then only to the extent that benefits were the inducement falsely offered to secure his membership – not to the plan itself.

The Alabama Supreme Court's opinion on this issue is consistent with the decisions of the Fifth and Sixth Circuit Courts of Appeals, the Michigan Supreme Court, and several federal district courts. *Wells v. General Motors Corp.*, 881 F.2d 166 (5th Cir. 1989)(action based upon false inducements to opt for different plan, *held* not preempted); *Perry v. P*I*E Nationwide, Inc.*, 872 F.2d 157 (6th Cir. 1989)(fraudulent inducement to participate in plan, *held* not preempted); *Teper v. Park West Galleries, Inc.*, 431 Mich. 202, 427 N.W.2d 535 (1988)(breach of oral assurances for lifetime employment, *held* not preempted); *Butler v. Fringe Benefits Plan, Inc.*, 701 F. Supp. 804 (N.D. Ala. 1988)(fraudulent inducement to switch plans and violation of Alabama twisting statute, *held* not preempted); *McNamee v. Bethlehem Steel Corp.*, 692 F. Supp. 1477 (E.D.N.Y. 1988)(misrepresentation of pension benefits to induce reemployment, *held* not preempted); *Quigley v. Unum Life Ins. Co.*, 688 F. Supp. 80 (D. Mass. 1988); *Greenblatt v. The Budd Co.*, 666 F. Supp. 735 (E.D. Pa. 1987)(misrepresentation that pension benefits under new plan equal benefits under old plan, *held* not preempted); *Morningstar v. Meijer, Inc.*, 662 F. Supp. 555 (E.D. Mich.

1987)(breach of employment contract). Several of these courts relied heavily upon this Court's decision in *Fort Halifax* in finding no preemption.

Petitioners contend (Pet. at 10 & 12) that the decisions of ten federal courts conflict with the Alabama Supreme Court's decision. However, only two of the decisions cited by petitioners, *Farlow v. Union Cent. Life Ins. Co.*, 874 F.2d 791 (11th Cir. 1989) and *Davidian v. Southern Cal. Meat Cutters Union*, 859 F.2d 134 (9th Cir. 1988), actually conflict, and these two cases did not consider this Court's important distinction between employee *benefits* and employee benefit *plans* as discussed in *Fort Halifax*. The eight remaining cases do not deal with claims asserting fraudulent inducement to *join* a plan.[4] Hence, the Alabama Supreme Court's decision on this issue actually conflicts with only the Ninth and Eleventh Circuits in

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[4] Two of the cases alleged misrepresentation of coverage for hospital admittance. These misrepresentations occurred well after the employees had been participants in the plans. *Hermann Hosp. v. MEBA Medical & Benefits Plan*, 845 F.2d 1286, 1287 (5th Cir. 1988) and *Comprehensive Care Corp. v. Doughtry*, 682 F. Supp. 516, 517 (S.D. Fla. 1988). The five remaining cases mention the word "fraud", but the claims did not involve fraudulent inducement to join a plan. *Johnson v. District 2 Marine Eng. Beneficial Ass'n*, 857 F.2d 514 (9th Cir. 1988); *Straub v. Western Union Tele. Co.*, 851 F.2d 1262 (10th Cir. 1988); *Reilly v. Blue Cross & Blue Shield of Wis.*, 846 F.2d 416 (7th Cir. 1988); *Phillips v. Amoco Oil Co.*, 799 F.2d 1464 (11th Cir. 1986); *Tucker v. Employers Life Ins. Co.*, 689 F. Supp. 1073 (N.D. Ala. 1988). Although petitioners assert (Pet. at 11) that the complaint in *Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir. 1987), alleged fraudulent inducement, the court's opinion makes no reference to fraudulent inducement to join the plan.

Farlow and *Davidian*. However, because neither *Farlow* nor *Davidian* deals with the second part of the Alabama Supreme Court's decision concerning the savings clause,[5] it cannot be said that these cases fully conflict with the Alabama Supreme Court's holding. Because the whole of the Alabama Supreme Court's decision does not conflict with the decisions of any federal circuit court, there exists no "special and important reasons" for granting the instant petition. S. Ct. R. 17.

II. THIS COURT SHOULD NOT GRANT REVIEW TO DECIDE WHETHER A STATE INSURANCE TRADE PRACTICES LAW "REGULATES INSURANCE" WITHIN THE MEANING OF ERISA'S SAVINGS CLAUSE

In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), this Court noted that ERISA's preemption clause is "substantially qualified by an 'insurance savings clause,' . . . which *broadly* states that, with one exception, nothing in ERISA 'shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.' " *Id.* at 733 (emphasis added)(citation omitted). The Court noted that ERISA's insurance savings clause saves "an entire body of law from the sweeping general pre-emption clause". *Id.* at 745 n.23. In discussing the various types of state insurance regulation, this Court specifically noted: "Group insurance is presently subject to extensive state regulation,

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[5] While an action under Alabama's twisting statute was raised in *Farlow*, the Eleventh Circuit never reached this issue: "Because we conclude that the twisting statute does not create a private cause of action, we do not address whether ERISA preempts this claim." 874 F.2d at 795 n.3.

including regulation of the carrier, regulation of the *sale and advertising of the insurance*, and regulation of the content of the contracts." *Id.* at 727-28 (emphasis added).

This Court further recognized that Congress designed the ERISA savings clause to preserve the McCarran-Ferguson Act's reservation of the regulation of the business of insurance to the states.[6] Therefore, as aptly stated by petitioners (Pet. at 20), "a Court must consider the case law interpreting the phrase 'business of insurance' under the McCarran-Ferguson Act" in deciding which state laws "regulate insurance" for the purpose of ERISA's savings clause. Pet. at 20 (citing *Pilot Life v. Dedeaux*).

In *FTC v. National Cas. Co.*, 357 U.S. 560 (1958), this Court held that the in-person solicitation of insurance by agents of an insurance company constituted the "business of insurance" within the meaning of the McCarran-Ferguson Act and was subject to state unfair trade practices laws prescribing unfair insurance advertising. *Id.* at 564.[7] In its opinion, this Court specifically noted that thirty-six states had enacted the "Model Unfair Trade Practices Bill". *Id.* at 565 n.6. Alabama's "Trade Practices Law",

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[6] "The ERISA savings clause, with its similarly worded protection of 'any law of any State which regulates insurance,' appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States. The savings clause in the McCarran-Ferguson Act served the same federal policy and utilized similar language to define what is left to the States." *Metropolitan Life*, 471 U.S. at 744 n.21.

[7] *See, also, SEC v. National Sec., Inc.*, 393 U.S. 453, 460 (1969)("selling and advertising of policies" constitutes "business of insurance").

including specifically the "twisting" statute, was adopted from the Model Unfair Trade Practices Bill. Ala. Code § 27-12-1; *Farlow v. Union Cent. Life Ins. Co.*, 874 F.2d 791, 796 (11th Cir. 1989).

Other courts have recognized that "[a]n insurance company's method of *inducing people to become policyholders* pertains to the company-policyholder relationship, and thus constitutes an integral part of the 'business of insurance' ". *Dexter v. Equitable Life Assurance Soc'y of the United States*, 527 F.2d 233, 235 (2nd Cir. 1975)(emphasis added); *see, also, Seasongood v. K & K Ins. Agency*, 414 F. Supp. 698, 701 (E.D. Mo. 1976)(convincing plaintiff to switch his insurance coverage constituted the "business of insurance") *rev'd on other grounds*, 548 F.2d 729 (8th Cir. 1977).

Thus, although petitioners insist (Pet. at 19) that the Alabama Supreme Court erred by not individually analyzing each of the McCarran-Ferguson factors utilized by this Court in *Pilot Life*, an individual analysis of such factors was clearly not necessary. This Court's previous decisions construing the McCarran-Ferguson Act clearly establish that state insurance trade practices laws are indeed laws which "regulate insurance".[8] Accordingly,

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[8] The cases cited by petitioners for the contrary position completely fail to consider the case law construing the McCarran-Ferguson Act. *Rollo v. Maxicare of La., Inc.*, 695 F. Supp. 245, 248 (E.D. La. 1988); *Keel v. Group Hospitalization Med. Serv.*, 695 F. Supp. 223, 227 n.13 (E.D. Va. 1988); *Denette v. Life of Ind. Ins. Co.*, 693 F. Supp. 959, 963-64 (D. Colo. 1988). Although the Fourth Circuit in *Powell v. Chesapeake & Potomac Tel. Co. of Va.*, 780 F.2d 419 (4th Cir. 1985) cites *SEC v. National Sec.*, the court did not consider that aspect of *SEC v. National Sec.* which expressly holds that state trade practices laws regulating the selling and advertising of insurance are within the scope of the McCarran-Ferguson Act. *Powell*, 780 F.2d at 423.

the Alabama Supreme Court correctly held that the twisting statute "regulates insurance". Opinion, Pet. at 18a.[9] This conclusion is supported by the Alabama Legislature's expression of purpose in enacting the Trade Practices Law: "The purpose of this chapter is to regulate trade practices *in the business of insurance* in accordance with the intent of congress as expressed in the [McCarran-Ferguson Act] . . . ." Ala. Code § 27-12-1(a)(emphasis added). Other courts confronted with state laws expressly designed to regulate the insurance business have concluded that civil actions based on those laws were saved from ERISA preemption. *Soniat v. Travelers Ins. Co.*, 538 So. 2d 210, 214-15 (La. 1989); *Locklear v. Visko's, Inc.*, 545 So. 2d 695, 696 (La. App. 1989).

Petitioners claim (Pet. at 19 & 22) that the twisting statute, when applied to HealthAmerica's solicitation activities, does not "regulate insurance" because HealthAmerica is a health maintenance organization, not an insurance company. However, HMO's, by statute, are expressly regulated by Alabama's Trade Practices Law. Ala. Code § 27-21A-13(b). The Alabama Legislature placed the laws governing the organization and operation of HMO's in the Alabama Insurance Code, indicating that

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[9] Petitioners also suggest (Pet. at 19) that the Alabama Supreme Court may have erred in finding a private cause of action under the twisting statute. However, the question of whether a state statute provides a private cause of action is a question of state law. *Farlow v. Union Cent. Life Ins. Co.*, 874 F.2d 791 (11th Cir. 1989). Moreover, the Alabama Supreme Court has previously held that a violation of the twisting statute supports a cause of action for fraud. *Jarrard v. Nationwide Mut. Ins. Co.*, 495 So. 2d 584, 586 (Ala. 1986).

HMO's are regarded as a form of insurance in Alabama. *See*, Ala. Code §§ 27-21A-1 *et seq*. The fact that the twisting statute applies to HMO's does not diminish its force as a law that regulates the business of insurance, particularly because HMO's compete against insurance companies for membership. The instant case serves as a perfect example of why HMO's are subject to the twisting statute. While an HMO might not meet the classic definition of an insurance company,[10] when an HMO competes for a share of the insurance market, it is subject to laws that "regulate insurance". In other words, the Alabama Supreme Court did not hold that petitioners were engaged in the "business of insurance"; rather, the court found that petitioners' solicitation activities were governed by a state law "regulating insurance". Opinion, Pet. at 18a.

Without specifying how, petitioners also contend that even if Mr. Menton's claim were saved, it would nevertheless be preempted because of its "disruption of ERISA's exclusive civil enforcement scheme". Pet. at 23. First, it bears repeating that Mr. Menton did not seek to enforce or recover any benefits *due under the terms of any plan*. Mr. Menton sought *damages* for the *destruction* of his insurance plan, not benefits under petitioners' plan. All

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[10] Although not determinative of the Alabama Supreme Court's decision, Mr. Menton asserted below that an HMO is functionally indistinguishable from health insurance. *See, Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 237-38 (1979)(Brennan, J. dissenting); *Physicians Health Plan, Inc. v. Citizens Ins. Co. of Am.*, 673 F. Supp. 903 (W.D. Mich. 1987); *West Michigan Health Care Network v. Transamerica Ins. Corp. of Am.*, 167 Mich. App. 218, 421 N.W.2d 638 (1987).

of the remedies enumerated in ERISA's civil enforcement scheme speak of actions to recover benefits, or to enforce or clarify rights to benefits, due "under the terms of the plan." 29 U.S.C. § 1132(a). See, Pet. at 58a-59a.

Second, even if the twisting statute creates disuniformity, which has not been established and is denied, "[s]uch disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985). Congress intentionally saved state laws like the twisting statute from preemption. Thus, application of the twisting statute in this case does not disrupt Congress' intention, but carries out its intention.

III. THIS COURT SHOULD NOT GRANT REVIEW TO DECIDE WHETHER ERISA'S FIDUCIARY AND DISCLOSURE REQUIREMENTS PERTAIN TO THE SOLICITATION OF PLAN MEMBERSHIP

This Court should not grant review to resolve petitioners' proposed fiduciary and disclosure issues for several reasons. First, because Mr. Menton's action is "saved" from preemption by the insurance savings clause, it is expressly not displaced by ERISA's fiduciary and disclosure provisions. As previously noted, Congress substantially qualified the preemptive effect of ERISA by broadly stating in the savings clause that "*nothing* in this subchapter shall be *construed* to exempt or relieve any person from any law of any State which regulates insurance . . . ." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 733 (1985); 29 U.S.C. § 1144(b)(2)(A). With this statement, Congress could not have made its intent any

clearer that *nothing* in ERISA, which includes the fiduciary and disclosure provisions, shall be *construed* to exempt or relieve any person from state laws regulating insurance. Because petitioners' fraudulent conduct was regulated by the Alabama twisting statute, the fiduciary and disclosure requirements cannot be invoked to relieve petitioners of liability.

Second, petitioners' proposed fiduciary and disclosure issues were neither raised in nor resolved by the courts below. Petitioners never sought to remove this case to federal district court on the basis of ERISA, and waited fourteen months after the action had been filed (barely a month before trial) to raise ERISA preemption as a defense. Moreover, petitioners did not so much as suggest in the trial court that ERISA's fiduciary and disclosure provisions might be applicable to this action. Consequently, as petitioners admitted in the court below, "there is little evidence in the record as to Menton's possible ERISA claim against the administrator or fiduciaries of the MPR's employee welfare benefit plan."

Likewise, petitioners did not suggest the potential applicability of the fiduciary and disclosure provisions before the Alabama Supreme Court until the filing of their reply brief. The Alabama Supreme Court does not review issues raised for the first time on appeal. *Stephens v. Central of Ga. R.R. Co.*, 367 So. 2d 192, 194-95 (Ala. 1979). As a result, neither court below made any findings of fact relevant to these issues nor considered or resolved the potential applicability of these provisions.

The difficulty created by the absence of factual findings in resolving these important issues is well illustrated by petitioners' arguments. For example, petitioners assert

that the Press Register "may" have failed to provide Mr. Menton with a sufficient description of HealthAmerica's plan and "may" have failed to make a copy of the plan available (Pet. at 15); that "if" Mr. Menton had made a written request for a complete schedule of benefits and "if" the Press Register had failed to comply, neither of which occurred, the Press Register would have violated a disclosure requirement (Pet. at 15-16); that Merle, *assuming* she was a fiduciary, "may" have breached a fiduciary duty (Pet. at 17); that "if" Mr. Menton failed to pursue formal grievance procedures because of a statement made by a HealthAmerica employee, HealthAmerica "could" be liable for breach of fiduciary duty (Pet. at 17).

Obviously, petitioners' failure to timely raise the fiduciary and disclosure provisions in the courts below has resulted in the total absence of a properly developed record from which this Court might decide these important issues.

> "It is the general rule, of course, that a federal appellate court does not consider an issue not passed upon below . . . . [T]his is 'essential in order that parties may have the opportunity to offer all the evidence they believe relevant to the issues . . . [and] in order that litigants may not be surprised on appeal by final decision there of issues upon which they have had no opportunity to introduce evidence.' "

Singleton v. Wulff, 428 U.S. 106, 120 (1976)(citation omitted); *see, also, Browning-Ferris v. Kelco Disposal*, 106 L.Ed.2d 219, 239 n.23 (1989) (Court declined review due to "the absence of a record on the due process point developed in the District Court and the Court of Appeals"). Petitioners' failure to raise the fiduciary and

disclosure provisions has forced petitioners to argue hypothetical facts, completely remote in some instances from the facts in this case, which, "may" have invoked fiduciary and disclosure obligations "if" they had occurred. This case obviously does not provide this Court with a practical opportunity to review these issues.

Third, the fiduciary and disclosure provisions plainly do not pertain to the *solicitation* of plan membership. Petitioners contend (Pet. at 15) that the Press Register "may" have violated ERISA's disclosure requirements by failing to provide Mr. Menton with a "sufficiently accurate and comprehensive" summary plan description and a copy of the HealthAmerica plan itself. However, the record clearly reflects that no violation of ERISA's disclosure requirements occurred. Assuming the Press Register was the "administrator" of the plan, ERISA does not require administrators to provide a summary plan description until ***after*** an employee becomes a participant in the plan. 29 U.S.C. § 1024(b)(1)(A). Hence, the Press Register was not obliged to provide Mr. Menton with a summary plan description until after he enrolled in HealthAmerica's plan.[11] Moreover, Mr. Menton did not contend that the Press Register provided an inaccurate

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[11] For this reason, both *Rodriguez v. MEBA Pension Trust*, 872 F.2d 69 (4th Cir. 1989) and *Davis v. Liberty Mut. Ins. Co.*, 871 F.2d 1134 (D.C. Cir. 1989), cited by petitioners (Pet. at 15), are inapplicable. Both cases involve failure to supply the employee with a summary plan description *after* he became a participant.

summary plan description.[12] Furthermore, ERISA requires administrators to provide participants with a copy of the actual plan instrument only "upon ***written request***" of a plan participant. 29 U.S.C. § 1024(b)(4) (emphasis added). It is undisputed that Mr. Menton did not request, in writing or otherwise, a copy of the plan instrument. Hence, ERISA's disclosure requirements were not violated under the facts of the instant case.

Petitioners also contend that Mr. Menton may have a claim for breach of fiduciary duty. To reach this conclusion, petitioners *assume* that Merle was, in fact, a fiduciary. There is no evidence to support this assumption in the record. ERISA defines the term fiduciary as follows:

> "[A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or

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[12] In three of the cases cited by the petitioners, the plaintiffs specifically alleged that the summary plan description was inaccurate or materially different from the terms of the plan instrument. *Edwards v. State Farm Mut. Auto. Ins. Co.*, 851 F.2d 134 (6th Cir. 1988); *McKnight v. Southern Life and Health Ins. Co.*, 758 F.2d 1566 (11th Cir. 1985); *Kochendorfer v. Rockdale Sash & Trim Co., Inc.*, 653 F. Supp. 612 (N.D. Ill. 1987). In *Genter v. Acme Scale & Supply Co.*, 776 F.2d 1180 (3rd Cir. 1985), the plaintiff alleged that the terms of the plan were contrary to the plan administrator's practice of allowing participants to increase life insurance benefits prior to the time specified in the plan. The instant case is clearly distinguishable.

> other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan."

29 U.S.C. § 1002(21)(A). There is no evidence that Merle possessed or exercised any discretionary authority or control over the management or administration of the plan or the disposition of its assets. To the contrary, Merle was simply a sales representative whose sole role was to solicit membership for HealthAmerica. As the court noted in *Berlin v. Michigan Bell Tel. Co.*, 858 F.2d 1154, 1160 (6th Cir. 1988), " 'before the court can determine whether a fiduciary violated his duties, the court must determine if he was acting as a fiduciary when he engaged in the disputed conduct.' " Even assuming Merle possessed some discretionary authority over the plan, she did not become a fiduciary with respect to Mr. Menton until after he became a participant in HealthAmerica's plan.[13]

Petitioners also suggest (Pet. at 17) that Mr. Menton "may" have failed to pursue formal grievance procedures. To support this contention, petitioners cite *Makar v. Health Care Corp. of Mid-Atl.*, 872 F.2d 80 (4th Cir. 1989). However, in *Makar*, the Plan removed the action to federal court and raised plaintiffs' failure to exhaust plan remedies as an affirmative defense. *Id.* at 82. In the

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[13] The cases cited by petitioners concern misrepresentations by fiduciaries to employees who were already participants in the plan. *Local Union 2134, United Mine Workers of America v. Powhatan Fuel*, 828 F.2d 710 (11th Cir. 1987); *Berlin v. Michigan Bell Tel. Co.*, 858 F.2d 1154 (6th Cir. 1988).

instant case, petitioners completely failed to raise this issue at any stage in these proceedings prior to the instant petition. Obviously, petitioners waived this defense.

ERISA's fiduciary and disclosure provisions have nothing whatsoever to do with the independent solicitation of plan membership, or other activities designed to induce employees to become members of a plan. ERISA does not speak to these activities because it was Congress' intent as expressed in the savings clause to preserve the regulation of these activities to the States. Any other holding would leave solicitation activities designed to induce employees to join employee benefit plans wholly unregulated by either ERISA or state law.

IV. THE COURT SHOULD NOT GRANT REVIEW IN THIS CASE TO DECIDE WHETHER THE DUE PROCESS CLAUSE LIMITS THE SIZE OF PUNITIVE DAMAGES AWARDS.

A. Petitioners' Failed to Timely and Properly Raise Any Federal Constitutional Challenges To The Size of the Punitive Damages Award

It is undisputed that petitioners did not raise any constitutional challenges to Alabama's process of awarding punitive damages until they filed motions for judgment notwithstanding the verdict and new trial, *twenty-nine days after the trial court had entered judgment on the jury's verdict*. App. at 25a. Under settled Alabama law, a party "cannot 'invoke action by a court and have a case tried on certain issues and then later, when dissatisfied with the result, raise an entirely new issue, such as the

constitutionality of the statutes under which he was proceeding, on motion for new trial.' " *Alabama Power Co. v. Capps*, 519 So. 2d 1328, 1330 (Ala. 1988), quoting, *Talley v. A&M Const. Co.*, 284 Ala. 371, 373, 225 So. 2d 359, 360 (1969), *cert. den.*, 397 U.S. 995 (1970). In Alabama, constitutional issues raised for the first time in a motion for judgment notwithstanding the verdict or new trial will not be considered on appeal. *Hicks v. Huggins*, 405 So. 2d 1324 (Ala. Civ. App.), *cert. denied*, 405 So. 2d 1328 (Ala. 1985); *Marion v. Hall*, 429 So. 2d 937 (Ala. 1983). For this reason, the Alabama Supreme Court correctly refused to consider petitioners' constitutional challenges. Opinion, Pet. at 25a.

Because the Alabama Supreme Court refused to review petitioners' constitutional challenges based upon valid, settled, Alabama procedural principles, this Court should follow its customary practice of refusing to grant review on questions not pressed or passed upon below. In *Bankers Life and Cas. Co. v. Crenshaw*, 100 L.Ed.2d 62 (1988), this Court noted that it declines to exercise its certiorari jurisdiction under circumstances such as in the instant case.

> "In determining whether to exercise jurisdiction over questions not properly raised below, the Court has focused on the policies that animate the 'not pressed or passed upon below' rule. These policies are first, comity to the States, and second, a constellation of practical considerations, chief among which is our own need for a properly developed record on appeal. See, *Webb v. Webb, supra*, at 500-501, 60 L.Ed.2d 392, 101 S.Ct. 1889. Because the chief issue appellant would have us resolve – whether the Eighth Amendment's Excessive Fines Clause serves to limit punitive damages in States' civil cases – is

> a question of some moment and difficulty, these policies apply with special force. See, *Illinois v. Gates, supra*, at 224, 76 L.Ed.2d 527, 103 S.Ct. 2317 ('where difficult issues of great public importance are involved, there are strong reasons to adhere scrupulously to the customary limitations on our discretion'); *Mishkin v. New York*, 383 U.S., at 512-513, 16 L.Ed.2d 56, 86 S.Ct. 958 ('The far-reaching and important questions tendered by this claim are not presented by the record with sufficient clarity to require or justify their decision')."

Id. at 72-73. The factors which led this Court to deny review of difficult constitutional issues in *Crenshaw* are present here. Petitioners have offered no compelling reason why the principles which led this Court to deny review in *Crenshaw* should not be followed in the instant case.

In the interest of comity, the Alabama Supreme Court has determined, as a matter of state law, that petitioners failed to timely raise any constitutional issues. Opinion, Pet. at 25a. Moreover, petitioners' failure to timely raise this issue below has resulted in the complete absence of a properly developed record. In the absence of such a record, the difficult constitutional questions proposed to be raised by petitioners would be made even more difficult.

B. Alabama Provides Substantial Standards and Procedures for Assessing and Reviewing Punitive Damages Awards

Petitioners do not here contend that the jury's verdict was the product of bias, passion, prejudice, corruption, or other improper motive, and the trial court found as a fact that it was not. Opinion, App. at 28a. Nor was the jury's

award the product of "unbridled and standardless" discretion. To the contrary, under recently augmented common law standards and procedures, jury discretion is constrained by very specific standards and instructions, and jury verdicts are subjected to searching post-trial review by trial and appellate courts to insure those verdicts are fair and reasonable. "If a defendant is dissatisfied with a jury's verdict, and feels that it is excessive, or otherwise flawed, he is entitled to the protection of a variety of safeguards." *Central Ala. Elec. Co-op. v. Tapley*, 546 So. 2d 371, 376 (Ala. 1989).

The Alabama Supreme Court has fashioned procedural and substantive safeguards to insure fair and consistent administration of punitive damages. Upon motion of a defendant, trial courts must hold *evidentiary hearings* and to provide written reasons for accepting or modifying a jury's verdict. *Hammond v. City of Gadsden*, 493 So. 2d 1374, 1378-79 (Ala. 1986); *Green Oil v. Hornsby*, 539 So. 2d 218, 223-24 (Ala. 1989). In deciding whether a particular award is excessive, the trial court is authorized to consider many factors, including the degree of reprehensibility of the defendant's conduct, defendant's awareness of the harm likely to be caused by his conduct and defendant's attempt to "cover-up" the wrongdoing. Trial courts are instructed that punitive damages should bear a reasonable relationship to the harm which was likely to occur from the defendant's conduct. *Hornsby* at 223-24; *Tapley* at 377. The defendant is permitted to present evidence to show that the jury's verdict is "unreasonable, disproportionate or economically destructive".

Industrial Chem. and Fiberglass Corp. v. Chandler, 547 So. 2d 812, 839 (Ala. 1988).[14]

The defendant may appeal "as a matter of right" from the trial court's denial of motions for remittitur or new trial and "is entitled to a *de novo* review of the jury's verdict on appeal." *Tapley*, 546 So. 2d at 376-77; Ala. Code § 12-22-71. Appellate courts are free to make their own independent assessment of the factual basis for the amount of the award, and can "order a new trial due to the excessiveness of the verdict", or can "order a new trial unless the plaintiff accepts a remittitur." *Id.* at 377 (citations omitted).

Petitioners had the benefit of all of these standards and procedures. The jury was properly instructed as to the law of punitive damages, including the admonition that the jury "must take into consideration the character and degree of the wrong as shown by the evidence in the case and the necessity of preventing similar wrongs in the future". After the jury's verdict, petitioners filed motions for judgment notwithstanding the verdict, a new trial and a remittitur. The trial court denied these motions and entered an order setting forth its reasons for finding that the award was not excessive. The trial court found that the "jury carefully and conscientiously followed the

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[14] "In sum 'fundamental fairness' requires that the defendant be given the opportunity to present proof to the trial court during post-judgment review of the verdict that the punitive award is unreasonable, disproportionate or economically destructive (the plaintiff, of course, is entitled to offer proof contradicting the defendant's, or, conversely, to offer proof that the award is inadequate)." *Industrial Chem.* at 839.

court's instructions in assessing damages in the case at $1,800,000.00" and that "there was clear and convincing evidence of fraud on the part of [petitioners], which in the Court's opinion fully justified the jury's verdict." Pet. at 49a. Petitioners appealed that decision as of right to the Alabama Supreme Court, which conducted a *de novo* review and affirmed the trial court in its entirety. Opinion, Pet. at 25a-28a.

Clearly, the unique post-judgment procedures afforded to and invoked by petitioners have protected them against any "arbitrary" action on the jury's part in awarding punitive damages. Accordingly, petitioners have been afforded all of the essentials of due process. *Browning-Ferris v. Kelco Disposal*, 106 L.Ed.2d 219, 242 (1989)(Brennan, J., concurring).

Petitioners have not cited any federal appellate cases which adopt the due process limitation on punitive damages they urge, because there are none.[15] To the contrary, courts that have addressed the issue have rejected any such due process limitations. *See, e.g., Miller v. Cudahy Co.*, 858 F.2d 1449, 1459 (10th Cir. 1988)("appellants have cited no persuasive federal constitutional authority to support their argument" [that the Fourteenth Amendment requires limits on award of punitive damages]), *cert. denied*, 109 S.Ct. 3265 (1989).

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[15] Petitioners do cite *Juzwin v. Amtorg Trading Corp.*, 705 F. Supp. 1053 (D.N.J. 1989). However, that court vacated its decision. 718 F. Supp. 1233. In any event, the court's due process ruling concerned "repetitive awards of punitive damages for the same conduct . . . ", 718 F. Supp. at 1234, which has not occurred in the instant case.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

HEALTHAMERICA AND PAMELA MERLE,
Petitioners,
v.
EDWARD MENTON,
Respondent.

On Petition for a Writ of Certiorari to the Supreme Court of Alabama

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QUESTION PRESENTED

Amicus curiae submits this brief in support of the petition for certiorari on the following issue:

Whether the Fourteenth Amendment's Due Process clause acts as a check on undue jury discretion to award punitive damages in a civil lawsuit in the absence of any express statutory limit.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

No. 89-939

HEALTHAMERICA AND PAMELA MERLE,
Petitioners,

v.

EDWARD MENTON,
Respondent.

On Petition for a Writ of Certiorari to the Supreme Court of Alabama

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BRIEF OF AMICUS CURIAE ALABAMA DEFENSE LAWYERS ASSOCIATION IN SUPPORT OF PETITION FOR CERTIORARI

INTEREST OF THE AMICUS[1]

The Alabama Defense Lawyers Association (hereinafter "ADLA") is a non-profit association of 640 members of the Alabama trial bar who devote a substantial amount of their professional time to representing defendants in civil lawsuits. Organized in 1964, its purposes include promoting improvements in the adversary system of jurisprudence and the administration of justice.

ADLA members collectively represent a substantial number of civil defendants against whom punitive damages are increasingly sought and awarded in Alabama. The ADLA has appeared as *amicus curiae* in numerous cases involving the constitutionality of large punitive

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[1] Pursuant to Rule 36, the parties' letters of consent have been filed with the Clerk.

damage awards, including *Aetna Life Insurance Co. v. Lavoie*, 475 U.S. 813 (1986), in which this Court recognized that such questions constitute "important issues which . . . must be resolved."[2]

Despite decisions by this Court questioning the constitutionality of large punitive damage awards, the Alabama Supreme Court has rejected all arguments that the Constitution affords any due process controls on punitive damages in civil cases where there is no fixed statutory limit. Because of the serious and unsettled problem of punitive damages in Alabama, *amicus* is vitally interested in securing plenary review of the question herein presented. In the event the Court declines to dispose of the judgment below pursuant to the ERISA arguments advanced by petitioners, *amicus* urges the Court to grant certiorari to review whether the $1.8 million award violates the Fourteenth Amendment's Due Process Clause.

REASONS FOR GRANTING THE WRIT

I. THE $1.8 MILLION PUNITIVE DAMAGE AWARD RAISES IMPORTANT FEDERAL QUESTIONS WHICH MUST BE RESOLVED.

This case presents an opportunity to address the question unanswered by *Bankers Life & Cas. Co. v. Crenshaw*, 486 U.S. 71 (1988), and *Browning-Ferris Indus., Inc. v. Kelco Disposal, Inc.*, [Ms., No. 88-556, June 26, 1989], —— U.S. —— (1989): "whether due process acts as a check on undue jury discretion to award punitive damages

[2] The case of *Aetna Life Ins. Co. v. Lavoie* involved a $3.5 million punitive damage award for the alleged bad faith failure to pay $1,650.00 in health insurance benefits. The judgment was fully affirmed by the Alabama Supreme Court in an opinion authored by a justice who simultaneously was a plaintiff in a separate bad faith lawsuit against another insurer. This Court vacated on grounds of judicial disqualification and did not reach the punitive damages issues. On remand, the Alabama Supreme Court remitted the award to $500,000.00. 505 So.2d 1050 (1987).

in the absence of any express statutory limit." Ms. at 18. As the $1.8 million punitive damage award illustrates, the problem of punitive damages is acute in Alabama, where substantial punitive damages have become routinely awarded and affirmed, most notably in the past five years. *See* Appendix *infra*. In the present case, unlike *Browning-Ferris* and *Bankers Life*, the due process argument was timely raised and expressly passed upon by the state trial court. Although *amicus* strongly supports the ERISA arguments asserted by petitioners, this brief addresses the importance of the due process question as it relates to Alabama law and the $1.8 million punitive damage award in this case.

A. The Problem of Punitive Damages in Alabama.

In Alabama, plaintiffs seeking punitive damages are not required to prove intentional or malicious conduct. Such damages may be imposed for wantonness or recklessness, with no greater state of mind requirement. Moreover, in wrongful death cases, in which compensatory damages are not available under Alabama law, substantial punitive damages can be and often are imposed upon proof of nothing more than ordinary negligence.

In addition, punitive damages may be awarded vicariously for the unauthorized acts of a defendant's agent, without any additional requirement of knowledge or fault on the part of the principal. *See, e.g., Pacific Mutual Life Ins. Co. v. Haslip*, [Ms. 87-842, Sept. 13, 1989], —— So.2d —— (Ala. 1989); *temporary stay granted*, [Ms. A-452 December 23, 1989], —— U.S. —— (1989 (Kennedy, J.). Punitive damages are paid entirely to the plaintiff, subject to attorney fees, on which there is no limitation or sliding scale. Alabama law further forbids apportionment of punitive damages among multiple defendants according to their respective wrongdoing. Punishment primarily accorded to one defendant's conduct may be enforced against another defendant under joint and several liability.

Statistics are unavailable but *amicus* represents that, as a result of these circumstances, a vast majority of civil tort actions filed in Alabama now include claims for punitive damages. There occasionally are legislative remedies prescribing the amount of damages which may be awarded due to the alleged wrongful conduct, e.g., as in this case, the failure to pay health insurance benefits.[3] However, the Alabama Supreme Court has never limited plaintiffs' recovery to the statutorily prescribed amount. Instead, Alabama trial courts generally follow the *Alabama Pattern Jury Instructions*, which addresses the amount of punitive damages in a single sentence, as follows:

> Should you award punitive damages, in fixing the amount, you must take into consideration the character and degree of the wrong as shown by the evidence in this case, and the necessity of preventing similar wrongs.

Alabama Pattern Jury Instructions 11.03 (1970). The jury then uses its discretion, based upon the evidence it has just heard, in assessing the amount of punitive damages. The hearing is not bifurcated, and the defendant's financial condition is not disclosed to the jury. However, plaintiffs' counsel commonly asks the jury to award punitive damages so substantial as to hurt the defendant financially and 'send a message' to other would-be tortfeasors in the state and/or nation through the news media. As Justice Brennan noted in *Browning-Ferris* regarding a jury instruction similar to the above, "guidance like this is scarcely better than no guidance at all." 109 S.Ct. 2923.

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[3] Prior to the Alabama Supreme Court's recognizing a common law cause of action for the tort of bad faith, for which punitive damages are recoverable, the 1980 Alabama Legislature enacted a statutory penalty in the amount of 1.5 percent per month against insurance companies for wrongfully withheld health insurance benefits. Ala. Code § 27-1-17 (1975). That amount in this case, for the 29-month period before trial, would total $1,049.22.

In Alabama, punitive damages have no objective upper limit, legislative or otherwise, of which the jury is made aware. As a result, punitive damage verdicts hugely disproportionate to the actual injury are not uncommon. A representative listing of fifty Alabama cases involving massive punitive damage verdicts, in the last five years alone, is reproduced in the Appendix, *infra*. As these cases illustrate, punitive damage verdicts fluctuate wildly for the same or similar offense and without regard to the amount of actual damages. Neither do the variations reflect a consistent scale of conduct.

In response to proliferating challenges to the excessiveness of jury awards, the Alabama Supreme Court has articulated a list of subjective factors to be considered by trial and appellate courts in analyzing the excessiveness of a jury award.[4] However, as the Appendix vividly illustrates, judicial oversight and review has not cured these defects because, without objective standards and limits, reviewing courts have no way of determining whether the jury adhered to any particular criteria. Similarly, requiring a "reasonable relationship" to actual damages affords no cure because any ratio of punitive to actual damages can and has been found to be reasonable. Judicial review of such awards, under present law, merely transfers subjective discretion to the reviewing courts without any objective limit on punishment.

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[4] *See Green Oil Co. v. Hornsby*, 539 So.2d 218 (Ala. 1989); *Hammond v. City of Gadsden*, 493 So.2d 1374 (Ala. 1986). The factors to be considered by the trial judge in determining whether the punitive damages award is excessive or inadequate include: (1) the award should bear a reasonable relationship to the harm, (2) the degree of reprehensible conduct should be considered, (3) any profit from the wrongful conduct should be removed, (4) the defendant's financial condition is relevant, (5) litigation costs should be included, (6) criminal sanctions already imposed should be considered, and (7) other civil actions against the same defendant for the same conduct should mitigate. *Green Oil Co. v. Hornsby*, 539 So.2d at 223-24.

Although not applicable to the present case, the 1987 Alabama Legislature enacted a "tort reform" package which included a statute limiting punitive damages judgments in some cases to $250,000. Ala. Code § 6-11-21 (Supp. 1989). However, the amount of the cap cannot be disclosed to the jury in assessing punitive damages and, thus, does not prevent a discretionary jury award in excess of $250,000. Where the jury does award more than $250,000, a plaintiff may argue that the case falls within one of the exceptions to the cap. Furthermore, the $250,000 limitation does not apply in actions for defamation or wrongful death, or cases where plaintiff proves the defendant's conduct was part of a "pattern of practice of intentional wrongful conduct." The breadth of those exceptions has not yet been construed by the Alabama Supreme Court. Equally as important, the validity of the cap itself is the subject of a fierce attack under the Alabama Constitution.[5]

Consequently, the problem of punitive damages exemplified by the $1.8 million verdict in this case remains unsettled. On several occasions the Alabama Supreme Court has considered, but rejected, federal constitutional challenges to large punitive damages awards, including the due process argument advanced here. Most recently, in *Land and Associates, Inc. v. Simmons*, [Ms. 87-1313 December 22, 1989] —— So.2d —— (Ala. 1989), the

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[5] *Trawick v. Michaels of Oregon Co.*, No. 88-C-413-N (M.D. Ala.). In *Trawick* a federal jury assessed $1 million in punitive damages for the alleged wantonness of a manufacturer of hunting accessories. Plaintiffs challenged the validity of the $250,000 tort reform "cap" and, in the alternative, asserted the "pattern or practice" exception to the cap on grounds that the product is mass produced. Those questions have been certified by the federal district court to the Alabama Supreme Court, prior to appeal of the merits, and the case is now pending. Similar challenges are pending in various state court cases. *See, e.g., Duvall, et al. v. General Motors Corp., et al.*, Circuit Court of Russell County, Case No. CV-88-190; *Foster v. Industrial Chemicals, Inc.*, Circuit Court of Jefferson County, Bessemer Division, Case No. CV-88-680.

Alabama Supreme Court expressly rejected a defendant's federal constitutional argument as follows:

> The defendants next contest the punitive damages aspect of the case. The defendants argue that the punitive damages award in this case [$2.5 million remitted to $600,000] is unconstitutional and violates the Fifth, Eighth and Fourteenth Amendments to the United States Constitution . . . . The Supreme Court of the United States has recently held in *Browning-Ferris Industries of Vermont, Inc. v. Kelco Disposal, Inc.* that the Excessive Fines Clause of the Eighth Amendment does not apply to punitive damage awards in cases between private parties. *Furthermore, this Court has consistently rejected the same arguments made by the defendants and has upheld the constitutionality of punitive damages.*

Ms. at 16 (citations omitted). The Alabama Supreme Court, instead, has come to rely upon the aforementioned subjective review standards for analyzing the excessiveness of an award after the verdict is rendered. No objective measures have been adopted to check the jury's unrestrained exercise of discretion. The appellate court must make a subjective *ad hoc* analysis of each verdict. If any application of federal constitutional principles is to be made in requiring an objective standard or limit, it must come from this Court.

B. Petitioners' Due Process Argument Was Timely and Properly Raised.

In recent cases involving punitive damages, this Court has declined to address the Fourteenth Amendment due process question because it heretofore was not adequately raised in the lower courts. That procedural impediment does not exist here.

After the jury verdict of $1.8 million, petitioners filed a timely post-trial motion challenging, *inter alia*, the excessiveness of the punitive damages verdict. Petitioners'

motion, containing 44 grounds for relief, included the following:

> 25. The jury's punitive damages award violates the Fourteenth Amendment . . . of the United States Constitution.

The trial court expressly considered and overruled petitioners' federal due process challenge as follows:

> [T]he Court has considered defendants' claims that the imposition of punitive damages, both generally under Alabama law and specifically in the amount and as returned by the jury under the facts of this case, is unconstitutional under the Alabama as well as the United States Constitutions (particularly, . . . the Due Process, Equal Protection, and Privileges and Immunities Clauses of the Fourteenth Amendment . . .). *Although these arguments were timely raised and effectively presented*, the Court is unpersuaded by such arguments and therefore holds that the imposition of punitive damages, both generally under Alabama law and specifically in the amount as returned by the jury under the facts of this case, is constitutional under both the State and Federal Constitutions.

Pet. at 48a (emphasis added). Despite this express holding by the trial court, the Alabama Supreme Court avoided ruling on the merits of the due process issue by citing the "not raised below" rule. Pet. at 25a. It held, in effect, that a challenge to the excessiveness of the punitive damages award on federal constitutional grounds, although asserted in a timely motion for new trial or remittitur, was too late.[6] Such holding was contrary to both the Alabama Rules of Civil Procedure and

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[6] The Alabama Supreme Court since has made it clear, citing the instant case *as precedent*, that it also rejects on the merits any argument that the federal constitution furnishes checks on unrestrained punitive damages awards. *See Land & Assoc., Inc. v. Simmons, supra.*

to recent pronouncements by the Alabama Supreme Court itself.

The Alabama Rules of Civil Procedure provide that a motion for new trial or remittitur, challenging the amount of the jury verdict, shall be filed "not later than 30 days *after* the entry of the judgment." *Ala.R.Civ. Pro.* Rule 59(b) and (f) (emphasis added). Indeed, it seems self-evident that petitioners' challenge to the size of the punitive damages verdict never ripened until the jury, in fact, had awarded $1.8 million. Petitioners thereafter raised their due process challenge at the first opportunity, through a timely motion for judgment notwithstanding the verdict or new trial. The trial court expressly acknowledged the motion's timeliness and overruled petitioners' due process argument on the merits.

Moreover, the Alabama Supreme Court, contrary to its holding in this case, has always observed the rule that challenges to the size of a punitive damages award are properly raised in a motion for new trial. *See, e.g., State Farm Mut. Auto. Ins. Co. v. Robbins*, 541 So.2d 478 (Ala. 1989). In *Robbins* the Alabama Supreme Court, presented with a nearly identical due process challenge to a $5 million punitive damages award, stated: "The . . . issue is whether excessive damages were awarded. *The question of excessive damages is raised by a motion for a new trial or remittitur.*" 541 So.2d at 478, citing *Ala.R.Civ.Pro.* Rule 59(f) (other citations omitted) (emphasis added).

The failure of the Alabama Supreme Court to evenhandedly apply that rule reinforces petitioners' assertion that the federal claim was adequately raised for purposes of this Court's review. The principle laid down in *Hathorn v. Lovorn* is particularly apt: "State courts may not avoid deciding federal issues by invoking procedural rules they do not apply evenhandedly to all similar claims." 457 U.S. 255, 263 (1982). In this case, there is

no procedural rule requiring petitioners to challenge the size of the punitive damages award before the verdict; indeed both the rule and the consistent practice of the Alabama Supreme Court are to the contrary.

For purposes of federal judicial review, petitioners' assertion of the due process argument in the above manner was sufficient to preserve that question for review under the decisions of this Court. *See Brinkerhoff-Faris Trust & Sav. Co. v. Hill*, 281 U.S. 673, 678 (1930) (federal claim was timely where raised by petitioners at the first opportunity). The federal due process claim was spefically raised at the first opportunity, and both the trial and appellate courts were given a full opportunity to consider the due process challenge to the size of the award. *See Illinois v. Gates*, 462 U.S. 213, 221 (1983). The procedural impediments in *Bankers Life* and *Browning-Ferris* therefore are not present here.

C. Due Process Checks Undue Jury Discretion to Impose Punitive Damages in the Absence of Any Express Statutory Limitations.

This Court is well familiar with the proposition that due process prohibits unrestrained punitive damage verdicts in civil cases. That argument was briefed and argued by appellants and *amici curiae* in *Bankers Life & Cas. Co. v. Crenshaw*, *supra*, and *Aetna Life Ins. Co. v. Lavoie*, *supra*, and is equally relevant here. A parallel argument under the Eighth Amendment's Excessive Fines Clause was advanced in *Browning-Ferris Indus., Inc. v. Kelco Disposal, Inc.*, *supra*.

As Justice Brennan recognized in *Browning-Ferris*, several decisions by this Court indicate that even where punitive damages are limited by statute, due process forbids damages that are grossly excessive or severely disproportionate to the offense. Ms. at 1 (Brennan, J., concurring), citing *Waters-Pierce Oil Co. v. Texas*, 212 U.S.

86, 111 (1909); *St. Louis, I. M. & S. R. Co. v. Williams*, 251 U.S. 63, 66-67 (1919).

In *Southwestern T & T. Co. v. Danaher*, 238 U.S. 482 (1914), the Court voided a punitive damages jury award of $6,300 as "so plainly arbitrary and oppressive as to be nothing short of taking of [defendant's] property without due process of law." *Id.* at 491. *See-also, Chicago etc. R. Co. v. Polt*, 232 U.S. 165 (1914); *Missouri Pacific Ry. Co. v. Tucker*, 230 U.S 340 (1913); *Ex Parte Young*, 209 U.S. 123 (1908); *Missouri Pacific Ry. Co. v. Humes*, 115 U.S. 512, 522-23 (1885). As these cases illustrate, due process controls over arbitrary and excessive punishments are not new. They have atrophied, however, through a trend, notably present in Alabama, toward passive jury deference.

The proposition that due process prohibits unrestrained punitive damage awards has been reinforced in recent opinions by Justices of this Court. Beginning with *Aetna Life Ins. Co. v. Lavoie, supra*, Chief Justice Burger, writing for a unanimous Court, commented on the due process question as being an "important [issue] which, in an appropriate setting, must be resolved." 475 U.S. at 828-29. Subsequently Justice O'Connor, joined by Justice Scalia, observed in *Bankers Life & Cas. Co. v. Crenshaw, supra*, that there is reason to think due process may forbid arbitrary and unrestrained punitive damages awards. 100 L.Ed.2d at 77. (O'Connor, J., concurring in part).

Most recently, in *Browning-Ferris Indus., Inc. v. Kelco Disposal, Inc., supra*, this Court acknowledged there is some authority for the application of the Due Process Clause to limit the size of civil punitive damage awards made within statutory limits. Ms. at 18. The Court, however, stopped short of answering the question presented in this case: "Whether due process acts as a check on undue jury discretion to award punitive damages in the absence of any express statutory limit." *Id.* Justices

Brennan and Marshall concurred, suggesting the Court would be even "less indulgent" of a punitive damage award made without the benefit of objective legislative limits. Ms. at 1 (Brennan, J., concurring). Justice O'Connor and Justice Stevens supported the Eighth Amendment Excessive Fines Clause argument advanced in that case, which is subsumed under the due process argument asserted here. Ms. at 1. (O'Connor, J., concurring and dissenting).

In the present case, the $1.8 million punitive award exceeds the measure of damages prescribed by the Alabama Legislature by 1,700 times.[7] The ratio of compensatory to punitive damages exceeds that in *Bankers Life, supra*, by factor of more than 650 times.[8] Furthermore, this award was the product of state laws as equally devoid of any objective limitations on a jury's discretion to determine the amount of punitive damages as those involved in *Browning-Ferris* and *Bankers Life*. Consideration of due process principles counsels that states must prescribe, according to the wrong committed, objective upper limits on the amount of punitive damages that may be awarded in a civil case.

Amicus submits the Fourteenth Amendment requires the imposition of upper limits on the *amount* of punitive damages which may be awarded, in advance of the trial. Any criminal procedure whereby jurors were given unrestrained discretion to impose unlimited punishment through fines or imprisonment surely would be regarded as barbaric. In effect, however, that is essentially the *status quo* for non-criminal defendants in Alabama,

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[7] *See* note 3, *supra*.

[8] In *Bankers Life & Cas. Co. v. Crenshaw, supra*, the jury awarded $20,000 in contract damages plus $1.6 million in punitive damages, a ratio of 80:1. The punitive award in the present case totalled more than $1,797,000, nearly 750 times the actual damages of $2,412.00 in unpaid contract benefits.

where juries are told, in the heat of the moment, to do what they think is best in determining an amount of punitive damages based upon evidence they have just heard. Policy decisions regarding the amount of punishment for given offenses ought to be made by the legislature in a cooler and more reasoned setting, not on an *ad hoc* basis by jurors having vastly different personalities, backgrounds, temperaments and societal concerns.

When actionable harm has resulted that cannot be rectified with money, there is an element of frustration and inclination toward vengeance. Such feelings readily become fury, which produces arbitrary and irrational results. Large corporations and insurance companies, perceived to have substantial resources, are inevitably targets for vengeance and frustrated fury. *See* Appendix, *infra*. The only means available for a jury to express its feelings of disapproval is to award a huge punitive damages verdict, as it did in this case. Such arbitrary and irrational actions, rendered in the heat of the moment without any objective limits, do not satisfy due process of law.

As long recognized in the criminal law, due process imposes the rule of law upon the impulse towards vengeance. It requires, at a minimum, objective upper limits on punitive damages awards, either in the form of a dollar limit, or a maximum ratio of punitive damages to actual damages, or both. The question not reached in *Bankers Life* and *Browning-Ferris* must be answered in the affirmative here: due process *does* act as a check on undue jury discretion to award punitive damages in the absence of any express statutory limit.

CONCLUSION

A resolution of the due process question is vitally important to Alabama civil defendants "hoping to protect their property." [9] In this case, the due process argument was squarely raised and passed upon in the state trial court and argued to the Alabama Supreme Court. Should this Court decline to review and vacate the judgment below on the alternate grounds advanced in the petition, *amicus* urges the Court to grant certiorari and set this case for oral argument on whether the $1,797,000 punitive damage award satisfies due process.

Respectfully submitted,

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[9] *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 429 (1982) (due process protects "civil litigants who seek recourse in the courts, either as defendants hoping to protect their property or as plaintiffs attempting to redress grievances").

APPENDIX

APPENDIX

REPRESENTATIVE LISTING OF LARGE PUNITIVE DAMAGES VERDICTS AND AFFIRMANCES IN ALABAMA DURING 1985-1989 [1]

A. *TORTS INVOLVING PUNITIVE DAMAGES* (non-wrongful death)

Holt v. State Farm Mut. Auto. Ins. Co., Circuit Court of Clay County CV-82-060 (1985): $25 million punitive damages for fraud involving uninsured motorist stacking. Settled post-trial.

McMillian v. Massey Ferguson, Inc., et al., Circuit Court of Mobile County CV-82-686 (1985): $10.5 million general verdict which included $584,000 actual damages for partial leg amputation caused by alleged wantonness in design and manufacture of grain auger. Settled pending appeal.

Sigafoose v. Babson Brothers Co., Circuit Court of Baldwin County CV-86-573 (1989): $10 million punitive damages for fraud involving $21,000 compensatory claim. Settled post-trial.

Super Valu Stores, Inc. v. Peterson, 506 So.2d 317 (Ala. 1987): $5 million punitive damages for breach of contract and fraud in employment relationship. Affirmed by Alabama Supreme Court.

Robbins v. State Farm Mut. Auto. Ins. Co., 541 So.2d 477 (Ala. 1989): $5 million punitive damages for bad faith

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[1] This table was prepared from *amicus* counsel's limited research and inquiries, and is believed to contain only a partial listing of large verdicts and affirmances for the given time period. There presently are no statewide records or databases maintained in Alabama to record the amounts of such verdicts, so this is the only available means of gathering such information. Should the Court grant certiorari on this issue, *amicus* will develop a comprehensive list of such awards for the Court's review.

and fraud involving $700 disability claim. Remitted to $500,000, affirmed by Alabama Supreme Court.

Turner v. Southern Life & Health Ins. Co., Circuit Court of Macon County (1988): $5 million punitive damages for bad faith and fraud involving $1,000 death benefit. Remitted to $500,000. Appeal pending.

Pasquale Food Co. v. Shakey's Inc., Circuit Court of Jefferson County (1985): $3 million punitive damages for intentional interference with business relationship and improper acquisition of trade secrets.

United Serv. Auto. Ass'n v. Wade, 544 So.2d 906 (Ala. 1989): $3.5 million non-jury punitive damages verdict for bad faith remitted to $2.5 million. Compensatory damages of $166,795 (plus $21,962.21 interest) on contract count. Affirmed by Alabama Supreme Court.

Aetna Life Ins. Co. v. Lavoie, 505 So.2d 1050 (Ala. 1987): $3.5 million punitive damages for bad faith refusal to pay $1,650 medical claim. Initially affirmed by Alabama Supreme Court, then vacated on appeal to U.S. Supreme Court, and thereafter remitted to $500,000 by Alabama Supreme Court and affirmed.

Lindblom v. Intercontinental Life Insurance Co., Jefferson County Circuit Court CV-86-7156 (1989): $3 million punitive damages for bad faith and fraud involving $10,000 death benefit. Appeal pending.

Ford v. Colonial Mortgage Co., Russell County Circuit Court (1989): $3 million punitive damages for fraudulent breach of residential home loan commitment. Post-trial motion pending.

American Pioneer Life Ins. Co. v. Sandlin, 470 So.2d 657 (Ala. 1985): $3 million punitive damages for fraud involving $100,000 compensatory damages. Affirmed by Alabama Supreme Court.

Land & Associates, Inc. v. Simmons, [Ms. 87-1313, December 22, 1989], —— So.2d —— (Ala. 1989): $2.5 mil-

lion punitive damages for fraud involving $10,000 in life insurance proceeds. Remitted to $600,000. Affirmed by Alabama Supreme Court.

HealthAmerica, et al. v. Menton, 551 So.2d 235 (Ala. 1989): $1.8 million punitive damages for fraud involving $2,400 claim for medical benefits. Affirmed by Alabama Supreme Court.

Phillips v. United American Ins. Co., Circuit Court of Etowah County (1987): $1.8 million punitive damages for bad faith and fraud involving $264 unpaid balanee on medical claim. Settled post-trial.

Walls v. Colonial Mortgage Co., Russell County Circuit Court, CV-87-194, (1988): $1.7 million punitive damages for fraud involving breach of residential home loan commitment. Settled pending appeal.

Nationwide Mut. Ins. Co. v. Clay, 469 So.2d 533 (Ala. 1985): $1.25 million punitive damages for bad faith involving $40,000 disability claim. Affirmed by Alabama Supreme Court.

Pacific Mutual Life Ins. Co. v. Haslip, [Ms. 87-842 Sept. 13, 1989] —— So.2d —— (Ala. 1989): $1 million punitive damages for fraud. Affirmed by Alabama Supreme Court.

Blackburn, et al. v. Altus Bank, Circuit Court of Mobile County, CV-89-2163 (1989): $1 million punitive damages ($500,000 per two plaintiffs) for fraud. Post-trial motion pending.

Trawick v. Michaels of Oregon Co., U.S. District Court for Middle District of Alabama, 88-C-413-N (December 21, 1988): $1 million punitive damages for products liability involving rifle swivel. Post-trial motions pending.

United American Ins. Co. v. Brumley, 542 So.2d 1231 (Ala. 1989): $1 million punitive damages for bad faith involving compensatory damages of $5,000. Affirmed by Alabama Supreme Court.

North Carolina Mut. Life Ins. Co. v. Holley, 533 So.2d 497 (Ala. 1987): $1 million punitive damages for bad faith, remitted to $500,000 by Alabama Supreme Court.

AmSouth Bank v. Speigner, 505 So.2d 1030 (Ala. 1986): $1 million punitive damages for wrongful completion, cashing of $25,000 check. Settled on appeal.

Thomas v. Principal Mut. Ins. Co., Mobile County Circuit Court No. CV-87-2561 (1989): $750,000 punitive damages for bad faith failure to pay $1,000 death benefit. Set aside by trial court on defendant's motion for J.N.O.V. Appeal pending.

Watson, Watson & Rutland v. Rosser Fabrap Int'l, Inc., U.S. District Court for Middle District of Alabama, 88-H-1292-N (M.D. Ala. 1989): $700,000 punitive damages for intentional interference with business relationship. Post-trial motion pending.

L. W. Johnson & Assoc. v. Rivers Constr. Co., 532 So.2d 618 (Ala. 1988): $500,000 punitive damages in fraud action by construction company against developer involving $165,000 compensatory damages. Affirmed by Alabama Supreme Court.

Vintage Enterprises v. Jay, 547 So.2d 1169 (Ala. 1989): $500,000 punitive damages, $20,000 compensatory, relating to sale, order, delivery of mobile home; fraud, wantonness, negligence, warranty, and Magnuson-Moss theories. Affirmed by Alabama Supreme Court.

State Farm Fire & Cas. Ins. Co. v. Lynn, 516 So.2d 1373 (Ala. 1987): $250,000 punitive damages, $25,000 compensatory, for fraud. Alabama Supreme Court ordered $4,078 remittitur of compensatory award and affirmed.

Wal-Mart Stores, Inc. v. Jones, 533 So.2d 551 (Ala. 1988): $200,000 punitive damages for false imprisonment. Affirmed by Alabama Supreme Court.

Kabel v. Brady, 519 So.2d 912 (Ala. 1987): $162,500 punitive damages, $609 compensatory, where chiropractor

fraudulently represented that Medicare would cover services performed. Affirmed by Alabama Supreme Court.

Dependable Ins. Co. v. Kirkpatrick, 513 So.2d 804 (Ala. 1987): $150,000 punitive damages for conversion of vacation cabin and its contents. Affirmed by Alabama Supreme Court.

Cooper Chevrolet, Inc. v. Chambers, 529 So.2d 913 (Ala. 1985): $150,000 punitive damages for intentional fraud in sale of used car. Affirmed by Alabama Supreme Court.

Hargrove v. Cantrell, 547 So.2d 488 (Ala. 1989): $127,717 punitive damages, $23,134 compensatory damages, for odometer rollback. Affirmed by Alabama Supreme Court.

Green Oil Co. v. Hornsby, 539 So.2d 218 (Ala. 1989): $150,000 punitive damages, $14,704.06 compensatory damages, for fraud. Punitive damages remitted to $25,000, affirmed by Alabama Supreme Court.

Mobile Dodge, Inc. v. Alford, 487 So.2d 866 (Ala. 1986): $125,000 punitive and compensatory damages (general verdict) for fraud by used car dealer. Affirmed by Alabama Supreme Court.

B. *WRONGFUL DEATH CASES* [2]

Hicks v. Ireland, Circuit Court of Montgomery County (1985): $25 million punitive damages for wrongful death, improper release of mentally ill patient who committed murder. Settled prior to appeal.

Whitt v. Burlington Northern Railroad, Circuit Court of Walker County (1988): $15 million punitive damages for

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[2] Under Alabama law, *only* punitive damages may be recovered in wrongful death actions. Although a separate category has been assigned here, the pattern jury instruction for punitive damages in wrongful death cases is substantially the same as in non-death cases. For purposes of evaluating due process limits on unrestrained punitive damages awards, the analysis is essentially the same.

wrongful death, railroad crossing accident. Appeal pending.

Thornton v. Knollwood Park Hospital, Mobile County Circuit Court Case No. CV-85-1275 (1989). $5 million punitive damages for wrongful death involving alleged failure to diagnose baby's spinal meningitis. Settled on appeal.

Industrial Chem. & Fiberglass Corp. v. Chandler, 547 So.2d 812 (Ala. 1988): $5 million punitive damages ($2.5 million each) for two deaths involving chemical tank burns. Affirmed by Alabama Supreme Court.

May v. Lloyd Noland Foundation, Jefferson County Circuit Court, (1985): $4 million punitive damages for wrongful death of baby. Settled post-trial.

General Motors Corp. v. Edwards, 482 So.2d 1176 (Ala. 1985): $4 million punitive damages ($2 million each) for two uncrashworthiness deaths. Remitted by trial court to $1.4 million each, which the Alabama Supreme Court affirmed.

Black Belt Wood Co. v. Sessions, 514 So.2d 1249 (Ala. 1986): $3.5 million punitive damages for wrongful death involving log truck improperly loaded. Affirmed by Alabama Supreme Court.

Olympia Spa v. Johnson, 547 So.2d 80 (Ala. 1989): $3 million punitive damages for wrongful death involving steam room scalding. Affirmed by Alabama Supreme Court.

Clardy v. Sanders, 551 So.2d 1057 (Ala. 1989): $2.75 million punitive damages for wrongful death in auto accident. Affirmed by Alabama Supreme Court.

Central Alabama Elec. Coop. v. Tapley, 546 So.2d 371 (Ala. 1989): $1 million punitive damages for wrongful death involving dump truck bed contacting power line. Affirmed by Alabama Supreme Court.

Alabama Power Co. v. Cantrell, 507 So.2d 1295 (Ala. 1986): $1 million punitive damages for wrongful death where decedent touched TV antenna to uninsulated power wires. Affirmed by Alabama Supreme Court.

Alabama Power Co. v. Courtney, 539 So.2d 170 (Ala. 1989): $750,000 punitive damages for wrongful death in auto accident. Affirmed by Alabama Supreme Court.

Consolidated Freightways v. Pacheco-Rivera, 524 So.2d 346 (Ala. 1988): $525,000 punitive damages for wrongful death in auto accident. Affirmed by Alabama Supreme Court.

Williams v. Price, 514 So.2d 1267 (Ala. 1986): $500,000 punitive damages for wrongful death involving drunk driving auto accident. Affirmed by Alabama Supreme Court.

Alabama Power Co. v. Capps, 519 So.2d 1328 (Ala. 1988): $500,000 punitive damages for wrongful death of dump truck driver killed when truck hit low lines. Affirmed by Alabama Supreme Court.

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No. 89-939

IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

HEALTHAMERICA AND PAMELA MERLE,
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EDWARD MENTON,
Respondent.

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BRIEF AMICI CURIAE FOR AMERICAN COUNCIL OF LIFE INSURANCE AND HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF THE PETITION

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QUESTIONS PRESENTED

1. Whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"), preempts a state common law claim of fraud against a health care provider for inducing an ERISA plan participant to elect coverage through the provider under an employer-sponsored benefit plan?

2. Whether a state "twisting" statute, which prohibits any legal entity from misrepresenting the benefits of an insurance policy to induce a policyholder to alter his coverage, is a law that "regulates insurance" and thus is saved from preemption under ERISA's insurance saving clause?

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HEALTHAMERICA AND PAMELA MERLE,
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---

BRIEF AMICI CURIAE FOR AMERICAN COUNCIL OF LIFE INSURANCE AND HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF THE PETITION

INTERESTS OF THE AMICI [1]

The American Council of Life Insurance ("ACLI") is the largest life insurance trade association in the United States, representing the interests of 616 member life insurance companies, 435 of which hold licenses to conduct insurance business in Alabama. The ACLI's members currently hold 95 percent of the life insurance in force in legal reserve life insurance companies in the United States and 92.6 percent of such insurance in Alabama.

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[1] Counsel for both the Petitioners and the Respondent have consented to the filing of this brief. Their consents are on file with the Clerk.

The Health Insurance Association of America ("HIAA") represents the interests of 320 member companies that write over 85 percent of the health insurance written by commercial insurance companies in the United States and are responsible for 23 percent of the health maintenance organization ("HMO") business in the United States. Approximately 230 HIAA member companies hold licenses in Alabama. The combined memberships of the HIAA and ACLI represent over 90 percent of the health insurance written by insurance companies in the United States.

Although Petitioner HealthAmerica is an HMO and not an insurer, the legal and practical consequences of the decision below—that the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"), does not preempt an Alabama common law and statutory action for fraud—are matters of grave concern to the members of the ACLI and HIAA. Many members provide group insurance policies to employers who voluntarily establish ERISA-covered employee benefit plans. As with any form of insurance, a predictable allocation of risks and costs, based upon historical patterns of claim payments, is essential to the financial integrity of a finite fund subject to partial liquidation upon the occurrence of events, such as illness or disability. By subjecting multi-state insurers that provide insurance to ERISA plans or undertake ERISA administrative responsibilities to suits under state common laws or statutory fraud laws, in addition to or in lieu of ERISA, the decision below drastically enlarges the exposure of such insurers to the varying standards of conduct that state laws impose; to the varying, and often inconsistent, remedies that those laws permit; and, in particular, to liability for substantial punitive damages awards—a liability that is entirely unpredictable under the many and varying state laws that permit such awards. This result is contrary to the national uniformity of decision that Congress intended to create when

it enacted ERISA. As a result of the unpredictability and lack of uniformity that the decision below creates, members of the ACLI and the HIAA may be unable to offer affordable group insurance policies to the many employers who sponsor insured benefit plans or to undertake administrative responsibilities for ERISA plans.

The ACLI and the HIAA thus have a direct and immediate interest in the issues presented in this case. While the ACLI and the HIAA fully support the Petitioners, they file this brief to provide the Court with their unique perspective on the ERISA issues that this case presents and to offer additional arguments that underscore the importance of this Court's review.

STATUTES INVOLVED

This case involves ERISA § 502, 29 U.S.C. § 1132, and ERISA § 514, 29 U.S.C. § 1144. The relevant portions of these provisions are set forth in the Appendix to this brief, *infra*, at 1a-2a.

STATEMENT

1. The facts essential to the resolution of the issues presented in the Petition are not in dispute.[2] Respondent Edward Menton ("Menton") is entitled to health insurance benefits under an ERISA-covered welfare benefit plan ("Plan") that his employer, the Mobile Press Register ("Press Register"), sponsors (Pet. App. at 1a). To provide the benefits under the Plan prior to 1985, the Press Register purchased a group insurance policy from Connecticut General Life Insurance Company ("Connecticut General") (*id.*). Under this Plan, Connecticut General paid 80 percent of the cost of physical therapy and medical appliances, including crutches, braces and walkers (*id.* at 2a).

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[2] This brief addresses only the ERISA issues in this case. This case also involves an issue with respect to punitive damages, and the amici fully support the arguments of the Petitioners and the amicus, the Alabama Defense Lawyers' Association, on that issue.

In June 1985, the Press Register expanded the coverage options available to its employees under the Plan (Pet. App. at 1a). As alternatives to the existing Connecticut General coverage, the Press Register offered its employees the option to choose medical coverage with either of two HMO's in Mobile, Alabama—Prime Health and Petitioner HealthAmerica (*id.*). To explain the coverage available to employees under these HMO alternatives, the Press Register distributed informational literature to its employees (*id.* at 2a). In addition, prior to the expiration of the enrollment period, representatives of the two HMO's described their programs at an informational meeting with the Press Register's employees (*id.*). Petitioner Pamela Merle ("Merle") represented HealthAmerica at this meeting (*id.*).

Menton attended this informational meeting three days before his son underwent surgery on his legs and, thereafter, began extended post-operative physical therapy (Pet. App. at 2a). At this meeting, the HMO representatives told the Press Register's employees that the HMO coverage was generally equal to, if not better than, the Connecticut General coverage (*id.*). Because Menton could not determine from the program literature whether HealthAmerica would cover his son's physical therapy treatments, however, he asked Merle to explain HealthAmerica's coverage of such expenses (*id.*). Menton asserted that Merle advised him that HealthAmerica would cover 100 percent of his son's medical expenses (*id.* at 3a). In reliance on this alleged conversation, Menton elected to participate in the HealthAmerica program rather than to maintain his coverage with Connecticut General (*id.*).

After enrolling in the HealthAmerica program, Menton received a schedule of benefits from HealthAmerica (Pet. App. at 3a). That schedule indicated that HealthAmerica covered physical therapy benefits at 100 percent, but only for a period of 60 days (*id.*). After confirming with HealthAmerica that the schedule of benefits correctly de-

scribed its coverage, Menton attempted to persuade HealthAmerica to provide unlimited coverage for his son's physical therapy expenses, which amounted to approximately $150 per week, based on the alleged misrepresentation made by HealthAmerica's representative at the informational meeting (*id.*). HealthAmerica declined to do so and paid benefits, at 100 percent, for 60 days (*id.*).

2. On October 28, 1986, Menton sued HealthAmerica and Merle for fraud in Alabama state court (Pet. App. at 3a). He alleged that HealthAmerica made material misrepresentations to him about the benefits available under its program and that he relied on those misrepresentations in dropping his Connecticut General coverage and electing coverage from HealthAmerica (*id.*). He further contended that HealthAmerica "has *denied coverage and refused to pay* for [his son's] physical therapy in the approximate amount of [$2,000] . . . and has additionally *refused to pay* for leg braces and crutches in the amount of approximately [$1,000] . . ." (emphasis added).

3. HealthAmerica moved for summary judgment, and for a directed verdict at the close of Menton's case, on the ground that ERISA preempted Menton's common law fraud action (Pet. App. at 3a). The trial court denied HealthAmerica's motions, concluding that ERISA did not preempt Menton's claim (*id.* at 3a-4a). It further concluded that, in any event, ERISA's insurance saving clause might "save" that fraud claim under Alabama's "twisting" statute, even though Menton had not alleged a violation of that statute (*id.*). The jury then returned a general verdict for Menton in the amount of $2,412.00 for actual damages, plus nearly $1.8 million for punitive damages (*id.* at 24a). After the verdict, Menton amended his complaint, over HealthAmerica's objection, to allege a violation of Alabama's twisting statute (*id.* at 4a).[3]

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[3] Alabama's Trade Practices Law, of which the twisting statute is a part, authorizes the State's insurance commissioner to enforce

4. The Alabama Supreme Court affirmed. It first held that ERISA did not preempt Menton's action because a claim for fraud in the inducement, "where the plaintiff alleges that he relied on misrepresentations made by the defendants in dropping his old hospital insurance and electing coverage under the defendant's plan," does not "relate to" an employee benefit plan (Pet. App. at 4a). In so holding, the court distinguished Menton's "fraud in the inducement" claim, which did not, in the court's view, seek benefits under a plan, from the common law claims at issue in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987). It stated that, "[a]lthough the complaint in *Pilot Life* contained a count for 'fraud in the inducement,' the opinion makes it unmistakably clear that the only claims [Dedeaux] pursued were claims seeking damages for improperly processing his claims for benefits under an ERISA-regulated plan" (Pet. App. at 7a). While the court noted that "there is authority on both sides" of this issue, it concluded that "the better reasoned cases, and those which recognize the dual role of state and federal law after ERISA, have reached the conclusion that" ERISA does not preempt such fraud claims (*id.* at 12a-13a). To buttress its conclusion, the court further relied on the analysis made by the authors of a pre-*Pilot Life* law review article to conclude that "[n]either Alabama's fraud statute nor the common law action for fraud purports to regulate, directly or indirectly, the terms and conditions of a plan, and the application of Alabama's fraud law to the facts of this case does not relate to or affect the administration of the plan" (Pet. App. at 15a, citing *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514*, 62 Tex. L. Rev. 1313, 1328-30 (1984)).

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its provisions with appropriate orders. The Eleventh Circuit has held that Alabama's "twisting" statute thus provides no private cause of action. *See Farlow v. Union Central Life Insurance Co.*, 874 F.2d 791 (11th Cir. 1989).

The court next concluded that the trial court correctly allowed Menton to amend his complaint, after the verdict, to allege a violation of Alabama's "twisting" statute (Pet. App. at 16a). It did so because (1) the amendment was redundant and did not prejudice HealthAmerica in that "every element underlying the 'twisting' statute is included in the plaintiff's complaint stating a common law cause of action for fraud" (*id.* at 16a), and (2) in the event that "some other court" decides that ERISA preempts Menton's fraud claim, "then we would hold that a claim under [the twisting statute] could still be maintained under the saving clause of ERISA as a state law regulating the business of insurance" (*id.*). Finally, relying on the Sixth Circuit's decision in *Perry v. P*I*E Nationwide, Inc.*, 872 F.2d 157 (6th Cir. 1989), the court concluded that ERISA preempts state laws only if it provides a remedy for the alleged wrong and concluded that "Congress has not provided a remedy for the wrong asserted by Mr. Menton . . ." (Pet. App. at 19a).[4]

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[4] Justices Houston and Maddox dissented, concluding that ERISA preempted Menton's fraud claim because the alleged misrepresentation clearly "related to" an employee benefit plan (Pet. App. at 33a). The dissenters further concluded that ERISA did not save Menton's fraud claim under Alabama's "twisting" statute (*id.* at 41a). Relying on the factors that this Court established in *Pilot Life*, they declined to "find that the 'twisting' statute affected a spreading of the risks among policyholders; or that the 'twisting' statute is more integral to the insurer-insured relationship than Alabama's misrepresentation statute, as developed from general principles of tort law; or that the statute in its definition of 'person' and 'insurer' is limited to entities in the insurance business" (*id.*). Finally, they concluded that "ERISA did not deny Menton a remedy" (*id.* at 42a), in that he could have sued under ERISA "to clarify and enforce his rights under the terms of the plan as represented to him, and to obtain equitable relief . . ." (*id.*, citing 29 U.S.C. § 1132(a)).

REASONS FOR GRANTING THE WRIT

I. THE ALABAMA SUPREME COURT'S DECISION THAT ERISA DOES NOT PREEMPT COMMON LAW FRAUD CLAIMS CONFLICTS WITH DECISIONS OF SEVERAL FEDERAL COURTS OF APPEALS AND UNDERMINES THE UNIFORMITY OF ERISA'S ENFORCEMENT SCHEME CONTRARY TO THIS COURT'S DECISION IN *PILOT LIFE*

Congress clearly intended ERISA's "virtually unique pre-emption provision" (*Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1, 24 n.26 (1983)) to be sweeping in scope—preempting state laws that "relate to" employee benefit plans in substance as well as in form. Once again, this provision raises a critically important issue for this Court's review: whether a state common law action for fraud may be used as a vehicle for avoiding the national uniformity that Congress intended to achieve when it enacted ERISA. The Alabama Supreme Court held that such a state action for fraud survives. Because that conclusion directly conflicts with the decisions of several federal courts of appeals, and threatens to undermine ERISA's exclusive enforcement scheme, this Court should grant review.

ERISA's "deliberately expansive" (*Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 46 (1987)) pre-emption provision, by its plain terms, "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." 29 U.S.C. § 1144(a). Giving "[t]he phrase 'relate to' . . . its broad commonsense meaning," this Court has held "that a state law 'relate[s] to' a benefit plan 'in the normal sense of the phrase, if it has a connection with or reference to such a plan.'" *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 739 (1985), quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983). This Court has, moreover, "emphasized that the pre-emption clause is not

limited to 'state laws specifically designed to affect employee benefit plans.'" *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. at 47-48, quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 98. To the contrary, ERISA's preemptive reach extends to the indirect effect of state laws because "even indirect state action . . . may encroach upon the area of exclusive federal concern." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981).

Despite the expansive breadth of ERISA § 514(a), confusion among the lower courts has prompted this Court on numerous occasions to define the contours of ERISA's "relate to" phrase. Thus, this Court has held that state statutes that apply to, and are specifically designed to affect, employee benefit plans clearly "relate to" such plans within the meaning of ERISA § 514. *See Mackey v. Lanier Collections Agency & Service*, 108 S. Ct. 2182, 2185 (1988) (state anti-garnishment statute); *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. at 739 (state mandated benefits statute). It has held, moreover, that state statutes that do not specifically refer to employee benefit plans, but nonetheless indirectly affect them, likewise "relate to" such plans. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. at 525 (state statute that prohibited the offsetting of pension benefits with workers compensation benefits); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 96-100 (state human rights statute and state disability benefits statute). Significantly, it has also held that generally-applicable common law causes of action, as applied to employee benefit plans, similarly "relate to" such plans under ERISA § 514. *See Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. at 47-48 (state common law tortious breach of contract, breach of fiduciary duty and fraud in the inducement claims); *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58, 62 (1987) (state common law breach of contract and tortious termination claims).

This Court has not, however, directly addressed ERISA's application to the precise state law claim at issue in this case. Though the common law fraud claim here is fundamentally indistinguishable from the state law claims that this Court addressed in *Pilot Life*, the state and federal courts are in conflict on the question whether state fraud in the inducement claims "relate to" an employee benefit plan under ERISA § 514. The Alabama Supreme Court held below that Menton's fraud claim did not "relate to" an employee benefit plan, in that he purportedly did not seek to recover benefits "under" the Plan. That decision draws support from the Sixth Circuit, which has concluded that ERISA does not preempt a state common law action based on an alleged fraud in inducing participation in an employer-sponsored benefit plan. *See Perry v. P*I*E Nationwide Inc.*, 872 F.2d 157 (6th Cir. 1989).

The decision of the Alabama Supreme Court stands in direct conflict with the decisions of two federal courts of appeals. The Eleventh Circuit has held that ERISA preempts plan participants' fraud claims under Alabama law arising, as here, from their *change of medical benefit coverage* under an ERISA plan in reliance on a provider's misrepresentations, even though the participants had not technically made a claim for benefits "under" the plan. *See Farlow v. Union Central Life Insurance Co.*, 874 F.2d 791 (11th Cir. 1989); *see also Belasco v. W.K.P. Wilson & Sons*, 833 F.2d 277 (11th Cir. 1987). The Ninth Circuit, in a similar context, has reached the same conclusion. *See Davidian v. Southern California Meat Cutters Union*, 859 F.2d 134 (9th Cir. 1988) (ERISA preempts state common law claim of fraud based on an alleged misrepresentation of coverage that induced employee to participate in a new benefit plan).[5]

---

[5] Other courts of appeals—including the Fifth, Sixth, Seventh, Ninth, and Tenth Circuits—that have considered whether ERISA preempts a state common law fraud or misrepresentation action in situations involving the *improper denial or processing of benefit*

This conflict among the state and federal appellate courts threatens to undermine ERISA's exclusive remedial scheme. If the decision below stands, other courts, like the Alabama Supreme Court and the Sixth Circuit, will permit participants in ERISA plans to pursue common law fraud actions in state courts that are, in substance, indistinct from a claim for benefits under those plans. Indeed, merely by contending that they do not seek benefits "under" an ERISA plan, but rather seek economic damages amounting to the "added" benefits that induced their alteration of coverage under the plan, these participants can—contrary to this Court's admonition—"avoid[] through form the substance of the preemption provision." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. at 525. Thus, in some jurisdictions, but not others, these participants can seek state law remedies

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claims have held that it does so. *See, e.g., Hermann Hospital v. MEBA Medical & Benefits Plans*, 845 F.2d 1286 (5th Cir. 1988); *Davis v. Kentucky Finance Cos. Retirement Plan*, 887 F.2d 689 (6th Cir. 1989); *Reilly v. Blue Cross & Blue Shield United*, 846 F.2d 416, 426 (7th Cir.), *cert. denied*, 109 S. Ct. 145 (1988); *Johnson v. District 2 Marine Engineers Beneficial Ass'n—Associated Maritime Officers, Medical Plan*, 857 F.2d 514 (9th Cir. 1988); *Nevill v. Shell Oil Co.*, 835 F.2d 209 (9th Cir. 1987); *Blau v. Del Monte Corp.*, 748 F.2d 1348 (9th Cir. 1984), *cert. denied*, 474 U.S. 865 (1985); *Straub v. Western Union Telegraph Co.*, 851 F.2d 1262 (10th Cir. 1988).

Even after *Pilot Life*, however, the federal district courts remain divided as to whether ERISA preempts common law fraud claims. Most of these courts have, since *Pilot Life*, held that ERISA preempts these claims. *See, e.g., Moffitt v. Blue Cross & Blue Shield, Inc.*, 722 F. Supp. 1391 (N.D. Miss. 1989); *St. Mary Medical Center v. Cristiano*, 724 F. Supp. 732 (C.D. Cal. 1989); *Settles v. Golden Rule Insurance Co.*, 715 F. Supp. 1021 (D. Kan. 1989); *Tucker v. Employers Life Insurance Co.*, 689 F. Supp. 1073 (N.D. Ala. 1988); *Childers v. Northwest Airlines, Inc.*, 688 F. Supp. 1357, 1364 (D. Minn. 1988); *Bohlmann v. Logos School*, 669 F. Supp. 951 (E.D. Mo. 1987). Others have declined to reach this conclusion. *See, e.g., Butler v. Fringe Benefits Plan*, 701 F. Supp. 804 (N.D. Ala. 1988); *Greenblatt v. Budd Co.*, 666 F. Supp. 735 (E.D. Pa. 1987).

that ERISA expressly supplanted with its comprehensive civil enforcement scheme rather than seek relief under ERISA § 502 and obtain recovery of benefits or enforce their perceived rights to past or future benefits under the plan.

Menton's recovery of nearly $1.8 million in punitive damages based on a state law fraud complaint, which plainly seeks to recover $3,000 in benefits that he believed HealthAmerica improperly "denied" and "refused to pay," vividly demonstrates this reality. Permitting such a recovery under state fraud law undermines the policy choices that prompted Congress to include certain remedies—and, significantly, to exclude others—under ERISA's comprehensive federal scheme. As this Court concluded in *Pilot Life*, "[t]he deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive." 481 U.S. at 54.

Appropriate protection of the area that Congress has made exclusively federal, and resolution of the conflicts among the state and federal appellate courts, can only be achieved through review by this Court.

II. THE ALABAMA SUPREME COURT'S DECISION THAT ERISA SAVES ALABAMA'S "TWISTING" STATUTE FROM PREEMPTION IS IRRECONCILABLE WITH THIS COURT'S DECISION IN *PILOT LIFE*, CONFLICTS WITH THE REASONING OF SEVERAL COURTS OF APPEALS IN ANALOGOUS CONTEXTS, AND UNDERMINES IMPORTANT POLICIES UNDERLYING ERISA

The decision below that ERISA's insurance saving clause protects Alabama's twisting statute from preemption rests on a misapplication of this Court's decision in *Pilot Life*. It sends a potent signal to disgruntled plan participants that is irreconcilable with the policies

underlying ERISA's preemption provision and its exclusive enforcement scheme: in order to escape ERISA's broad preemption of common law fraud claims, these plan participants need only plead an identical claim under a state insurance fraud statute. Because all states have enacted such statutes in some form (*see* discussion *infra*, at 16-17 and n.8 & n.9), the impact of the decision below on ERISA's exclusive enforcement scheme is far-reaching.

Resolution of this second issue, despite its significance, requires this Court to break no new legal ground. In *Pilot Life*, this Court carefully explained the analytical framework that guides courts in determining whether a state law "regulates insurance" (29 U.S.C. § 1144(b)) so that it is saved from preemption under ERISA's insurance saving clause. This Court first held that, under "a 'common-sense view' of the language of the saving clause itself" (481 U.S. at 48), a law cannot "regulate insurance" unless it is "specifically directed toward that industry." *Id.* at 50. It then held that courts must look to the three criteria that define the "business of insurance" under the McCarran-Ferguson Act to determine whether a state law falls within ERISA's insurance saving clause: "'*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.'" *Id.* at 48-49, quoting *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119, 129 (1982) (emphasis in original). Applying these standards in *Pilot Life*, the Court concluded that ERISA did not preserve Mississippi's law of "bad faith" because neither a "common sense" view of the saving clause nor the "business of insurance" criteria supported the conclusion that the law "regulate[d] insurance." 481 U.S. at 50-51.

The court below plainly misapplied this Court's decision in *Pilot Life*. Addressing only the first prong of this

Court's test, the Alabama Supreme Court held that the saving clause "saves" the twisting statute from preemption because the statute "specifically relates to the insurance industry" (Pet. App. at 18a). It did so even though it recognized that the elements of a twisting statute violation are precisely the same elements that support the generally-applicable theory of common law fraud (*id.* at 16a) and even though the twisting statute, by its terms, applies to all legal entities—including, but not limited to, individuals, insurers and corporations (*see* Ala. Code § 27-1-2(3)).[6] The court below did not, moreover, even attempt to apply the three "business of insurance" criteria to the twisting statute. It did not explain how the twisting statute transfers or spreads a policyholder's risk—which, as the dissent properly concluded, the law does not do (Pet. App. at 41a). It did not explain how, if at all, the law affects an integral part of the insurer-insured relationship. And it did not address the fact that the law applies not just to insurers, but to entities outside the insurance industry as well (*see* Ala. Code § 27-1-2 (3)). Having ignored these criteria, the court below reached the anomalous conclusion that, even if ERISA preempts claims of common law fraud, it "saves" precisely the same claims as "insurance regulation" under the state insurance statute.[7]

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[6] The twisting statute provides that no "person" shall misrepresent or make misleading comparisons about the terms, conditions, or benefits of an insurance policy "for the purpose of inducing, or attempting or tending to induce, the policyholder to lapse, forfeit, surrender, retain, exchange or convert any insurance policy." Ala. Code § 27-12-6. The statute defines "person" to mean "[a]n individual, insurer, company, association, organization, Lloyd's insurer, society, reciprocal insurer or interinsurance exchange, partnership, syndicate, business trust, corporation and every legal entity." *Id.*, § 27-1-2(3).

[7] In so concluding, the court below stated that a contrary decision would mean that Alabama's insurance commissioner "would be preempted from imposing the statutory sanctions against insur-

The federal courts of appeals, in related contexts, have declined to employ ERISA's saving clause to effectuate such a "form-over-substance" evasion of its preemption provision. In *Kanne v. Connecticut General Life Insurance Co.*, 859 F.2d 96, 99-100 (9th Cir. 1988), *cert. denied*, 109 S. Ct. 3216 (1989), for example, the Ninth Circuit considered a plan participant's claim that an insurer had improperly processed a benefit claim in violation of a state unfair insurance practices statute. The Ninth Circuit, however, declined to hold that ERISA's insurance saving clause "saved" the statutory claim. It based this conclusion on the fact that (i) the participant's statutory claim was virtually the same as his common law "bad faith" claim and (ii) this Court made clear in *Pilot Life* that ERISA is the exclusive vehicle for challenging actions asserting the improper processing of benefit claims. *Id.* at 100. The Fifth, Eighth and Eleventh Circuits have likewise refused to sanction similar efforts to evade ERISA preemption of claims under state insurance statutes through an overly-expansive reading of the saving clause. *See Ramirez v. Inter-Continental Hotels*, 890 F.2d 760 (5th Cir. 1989) (state insurance and trade practices statute not saved from preemption as law regulating insurance); *In re Life Insurance Co. of North America*, 857 F.2d 1190, 1193-95 (8th Cir. 1988) (state vexatious refusal to pay insurance benefits statute not saved from preemption as law regulating insurance); *Anschultz v. Connecticut General Life Insurance Co.*, 850 F.2d 1467, 1468-69 (11th Cir. 1988) (state insurance practices statute not saved from preemption as law regulating insurance).

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ance companies that violate § 27-12-1 et seq." (Pet. App. at 18a). This statement is unwarranted. ERISA preempts state laws only "*insofar* as they . . . relate to any employee benefit plan." 29 U.S.C. § 1144(a) (emphasis added). To the extent that Alabama's insurance commissioner seeks to enforce the twisting statute in contexts not involving any employee benefit plan, nothing in ERISA precludes him from doing so.

In sharp contrast with the well-reasoned decisions of these courts of appeals, the Alabama Supreme Court has endorsed precisely such a back-door evasion of ERISA's exclusive enforcement scheme that will have serious effects on ERISA plans nationwide. Fourteen other states have included "twisting" provisions in their insurance codes that are identical or similar to the Alabama statute at issue in this case.[8] All other states have enacted similar "misrepresentation" provisions as part of their unfair trade practices statutes or insurance codes.[9] To the

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[8] *See* Alaska Stat. § 21.36.050 (1989); Cal. Ins. Code § 781 (West 1972); Del. Code Ann. tit. 18, § 2304(20) (1975); Fla. Stat. Ann. § 626.9541(1) (West 1984); Idaho Code § 41-1305 (1977); Ky. Rev. Stat. Ann. § 304.12-030 (Michie 1988); Me. Rev. Stat. Ann., tit. 24-A, § 2155 (1974); Md. Ann. Code Art. 48A, § 227 (1986); Mont. Code Ann. § 33-18-204 (1989); Nev. Rev. Stat. Ann. § 686A.050 (Michie 1986); N.M. Stat. Ann. § 59A-16-6 (Supp. 1988); S.D. Codified Laws Ann. § 58-33-8 (1978); Wash. Rev. Code Ann. § 48.30.180 (1984); Wyo. Stat. Ann. § 26-13-105 (1977).

[9] *See* Ariz. Rev. Stat. Ann. § 20-443(5) (Supp. 1989); Ark. Code Ann. §§ 23-66-206(1)(F), 23-66-306(a) (1987 & Supp. 1989); Colo. Rev. Stat. § 10-3-1104(1)(a)(VI) (1987); Conn. Gen. Stat. Ann. § 38-61(1)(f) (West 1988); D.C. Code Ann. § 35-519 (1988); Ga. Code Ann. § 33-6-4(b)(2) (Supp. 1989); Haw. Rev. Stat. § 431-643(1)(F) (1985); Ill. Ann. Stat. ch. 73, para. 761 § 149(2) (Smith-Hurd Supp. 1989); Ind. Code Ann. § 27-4-1-4(1)(E) (West Supp. 1989); Iowa Code Ann. § 507B.4(1)(f) (West 1988); Kan. Stat. Ann. § 40-2404(1)(f) (1986); La. Rev. Stat. Ann. § 22:1214(1) (West 1978); Mass. Gen. Laws Ann. ch. 176D § 3(1)(f) (West 1987); Mich. Comp. Laws Ann. § 500.2005(f) (West 1983); Minn. Stat. Ann. § 72A.20(1) (West 1986); Miss. Code Ann. § 83-5-35(a) (1973); Mo. Ann. Stat. § 375.936(6)(f) (Vernon Supp. 1989); Neb. Rev. Stat. § 44-1525(1)(f) (Supp. 1989); N.H. Rev. Stat. Ann. § 417:4(I) (1983); N.J. Stat. Ann. § 17:29B-4(1) (West 1985); N.Y. Ins. Law §§ 2123, 2402-03 (McKinney 1985 & Supp. 1990); N.C. Gen. Stat. § 58-54.4(1) (1982); N.D. Cent. Code § 26.1-04-03(1) (1989); Ohio Rev. Code Ann. § 3901.21(A) (Anderson 1989); Okla. Stat. Ann. tit. 36, § 1204(1) (West Supp. 1990); Or. Rev. Stat. Ann. § 746.075(1) (Butterworth 1989); Pa. Stat. Ann. tit. 40, § 278 (Purdon 1971); R.I. Gen. Laws § 27-29.4(1) (1989); S.C. Code Ann. § 38-57-60

extent that these statutes authorize private actions, the decision below encourages ERISA plan participants in these states to pursue, in substance, preempted common law fraud claims in the form of purported violations of the "twisting" or "misrepresentation" provisions of state insurance codes. It thus allows participants to employ artful pleading tactics, as Menton did here, to ensure that state courts will decide their disguised claims for ERISA plan benefits and will award them state law remedies, including massive punitive damages awards like the aggregate $1.8 million award in this case.

This result is wholly at odds with the intention of Congress that ERISA's civil enforcement provisions shall be the exclusive vehicle for actions that—regardless of their title or form—seek benefits under an employee benefit plan. *See Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. at 51-56; *see generally* Note, *Defining the Contours of ERISA Preemption of State Insurance Regulation: Making Employee Benefit Plan Regulation an Exclusively Federal Concern*, 42 Vand. L. Rev. 607, 632 n.154 (1989). The decision below thus spawns precisely the type of disuniformity of decisions, under many and varying state laws, that Congress sought to avoid in ERISA.

(Law. Co-op. 1989); Tenn. Code Ann. § 56-8-104(1)(F) (1989); Tex. Rev. Civ. Stat. Ann. art. 21.21 § 4(1) (Vernon 1981); Utah Code Ann. § 31A-23-302(1)(a)(i) (Supp. 1989); Vt. Stat. Ann. tit. 8, § 4724(1)(F) (1984); Va. Code Ann. § 38.2-502(6) (1986); W. Va. Code § 33-11-4(1)(f) (1988); Wis. Stat. Ann. § 628.34(2) (West 1980).

CONCLUSION

The recent observation of the Second Circuit in *General Electric Co. v. New York State Department of Labor*, 1989 U.S. App. LEXIS 18243 (2d Cir. Nov. 29, 1989), is highly pertinent here. It said that the problem with courts "adjudicating in the same area but reaching inconsistent results . . . is exactly what ERISA was designed to prevent." Only this Court can restore "[t]he uniformity of decision which [ERISA] is designed to foster." H.R. Rep. No. 533, 93d Cong., 1st Sess. 12 (1973).

The Petition for a Writ of Certiorari should be granted.

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January 1990

APPENDIX

APPENDIX

FEDERAL STATUTORY PROVISIONS

1. ERISA § 502(a), 29 U.S.C. § 1132(a), provides that:

> A civil action may be brought—
>
> (1) by a participant or beneficiary—
>
> (A) for the relief provided for in subsection (c) of this section, or
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
>
> (2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 [the fiduciary provisions] of this title;
>
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan. . . .

2. ERISA § 514(a), 29 U.S.C. § 1144(a), provides that:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

3. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), the so-called "insurance saving clause," provides that:

> Except as provided in paragraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

Supreme Court, U.S.
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No. 89-939

In The

Supreme Court of the United States

October Term, 1989

HEALTHAMERICA AND PAMELA MERLE,

Petitioners,

v.

EDWARD MENTON,

Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF ALABAMA

REPLY MEMORANDUM

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REPLY MEMORANDUM

I. MENTON'S COMMON LAW FRAUD CLAIM IS PREEMPTED AND THE OPINION OF THE ALABAMA COURT IS IN DIRECT CONFLICT WITH FEDERAL APPELLATE DECISIONS

Menton conceded that the decisions of the Ninth and Eleventh Circuits, in *Farlow v. Union Central Life Ins. Co.*, 874 F.2d 791 (11th Cir. 1989) and *Davidian v. Southern California Meatcutter's Union*, 859 F.2d 134 (9th Cir. 1988), directly conflict with the holding of the Alabama Supreme Court that his common law fraud claim is not preempted.[1] This direct conflict must be resolved.

Menton argues that the recent opinion of the Fifth Circuit in *Wells v. General Motors Corporation*, 881 F.2d 166 (5th Cir. 1989), supports the opinion of the Alabama Supreme Court. Contrary to Menton's analysis, the Court merely held that the employer's Voluntary Termination of Employment Plan, offering severance payments, was not an ERISA "employee benefit plan" and, therefore, ERISA preemption was not applicable. The Fifth Circuit has not changed its

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[1] Menton insinuates that the eleventh Circuit decision in *Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir. 1987), does not directly conflict with the opinion of the Alabama Supreme Court. (Opp. at 12, n4). However, Menton is careful not to deny that the amended complaint in *Belasco* (which was presented to the Alabama Supreme Court, Pet. App. at 33a) included a claim for fraudulent inducement virtually identical to Menton's claim: the plaintiffs in *Belasco* alleged they were induced into purchasing dependent protection under an ERISA governed plan and, also in reliance upon representations regarding coverage under the plan, into *discontinuing* their dependent coverage under an *existing policy* of insurance. (Para. 15-22 of the amended complaint, submitted to the Supreme Court of Alabama with the May 19, 1989, letter brief of the Appellants). Thus, the Eleventh Circuit has consistently held that Alabama fraud claims based upon representations concerning coverage available under an ERISA benefit plan, including claims that the employee dropped existing coverage and switched to a different coverage in reliance, "relate to" the administration of the welfare plan and are preempted.

holding in *Hermann Hospital v. MEBA Medical & Benefits Plan*, 845 F.2d 1286 (5th Cir. 1988), where it ruled that a fraud claim by even a non-participant (a healthcare provider) based upon representations that an individual was covered under the plan "related to" the plan and was preempted. *Id.* at 1290. Petitioners respectfully suggest that in the Fifth Circuit a fraud claim like Menton's, based upon representations concerning benefits available under the plan, is preempted on authority of *Hermann Hospital. See also Cefalu v. B.F. Goodrich Co.*, 871 F.2d 1290 (5th Cir. 1989).

Menton also argues that the Petitioners were not "explaining coverages and options" within the Press Register's benefit plan. (Opp. at 10). To this contention, Petitioners would direct the court's attention to the facts as outlined in their Petition to this court and in Menton's Opposition. Clearly, Menton's fraud claim arose out of and "relates to" the administration of the Press Register's welfare benefit plan.[2]

It is undisputed that Menton was already a participant in the Press Register's welfare benefit plan when he selected one of the "alternative medical benefit selections" offered by the Press Register in the spring of 1985. Menton selected the HealthAmerica alternative because of Merle's incorrect answer to his specific coverage question at a meeting held for Press Register employees during which they could ask coverage questions about the three "medical benefit selections" that comprised the benefit plan. By contract entered on May 15, 1985, HealthAmerica became part of the Press Register's plan (one of the "alternative medical benefit selections") over a month before the June 17 meeting when Menton asked his

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[2] Further, as was aptly pointed out in the Brief Amici Curiae for American Counsel of Life Insurance and the Health Insurance Association of America, at p.5, Menton contended in his fraud claim that HealthAmerica "denied coverage and refused to pay for" his son's physical therapy and "refused to pay" for certain medical appliances. Clearly, Menton's claim is based not only on his dropping of Connecticut General coverage but also upon HealthAmerica's denial and refusal to pay his claim for benefits. It is axiomatic that a claim for the denial or refusal to pay benefits "relates to" the plan.

coverage question. It is undisputed that Menton was a participant in his employer's existing benefit plan when he elected to switch to another "medical benefit selection" or option within that same plan. Under the applicable authorities, the ERISA governed welfare plan was the benefit package (including the alternate medical benefit selections) offered by Menton's employer. Accordingly, Menton's attempt to distinguish the cases relied upon by Petitioners as involving representations made *after* the employee became a participant in the ERISA plan is without merit.[3]

At the very least, the opinion of the majority of the Supreme Court of Alabama with regard to Menton's common law fraud claim (the only claim presented to the jury) directly conflicts with the decisions of the eleventh and Ninth Circuits. Petitioners suggest that it is also in conflict with the decisions of the Fifth Circuit, the ERISA preemption analysis of this court in *Pilot Life*, and the other authorities relied upon by Petitioners. Review by this Court is necessary to resolve these conflicts.

II. WHETHER MENTON'S CLAIM UNDER ALABAMA'S TWISTING STATUTE IS "SAVED" FROM ERISA PREEMPTION

Menton argues that Alabama's twisting statute "saves" his claim from ERISA preemption because it is a law which "regulates insurance." Menton cites, for the first time, certain cases applying the McCarran-Ferguson Act in connection with the advertising and sale of *insurance policies* by

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[3] Menton, also argues that his claim "concerns the destruction of his old plan," because he was induced to "drop" his existing Connecticut General Health Insurance. If his claim is based on the "destruction" or dropping of his Connecticut General Insurance (provided through an existing ERISA governed welfare benefit plan) in favor of an "alternative medical benefit selection" within the same welfare benefit plan, such a claim surely "relates to" the benefit plan.

insurance companies.[4] None of these authorities were cited to or considered by the Alabama Courts. For several different reasons, Menton's argument and newly cited authorities provide further reason for this Court to grant review in this case.

HealthAmerica is a health maintenance organization and did not issue or sell any policy of insurance. Accordingly, the cases relied upon by Menton simply do not apply to the activities of HealthAmerica. *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). Menton's argument that the activities of HMOs *should be* subject to state insurance regulation is without support in the decisions of this Court.[5]

The authorities relied upon by Menton, including *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985), predate *Pilot Life*. Accordingly, they do not consider what this court considered most significant, i.e., the relationship between the application of the specific state law and the role of the savings clause in ERISA in light of ERISA's exclusive civil enforcement scheme. Menton's authorities do not consider the effect of allowing punitive awards under the different states' trade practices acts for conduct which "relates to" the benefit plan and which is specifically

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[4] *FTC v. National Cas. Co.*, 357 U.S. 560 (1958); *Dexter v. Equitable Life Assurance Society of the United States*, 527 F.2d 233 (2nd Cir. 1975); *Seasongood v. K & K Insurance Agency*, 414 F.Supp. 698 (E.D.Miss. 1976), *rev'd on other grounds*, 548 F.2d 729 (8th Cir. 1977).

[5] Menton's argument that HMOs are regarded as a form of insurance in Alabama, according to the provisions of the Alabama HMO Act (*Ala. Code*, §§27-21a-1 through 27-21a-32) is shocking. Menton has previously conceded that Alabama's HMO provisions (including §27-21a-13b and §27-21a-1) have no application in this lawsuit because the HMO statute did not become effective until *after* Menton's claims accrued and the HMO statute could not be given retrospective effect. (Appellee's Brief, p.62, filed January 13, 1989). If the twisting statute is to be saved from ERISA preemption as a law regulating insurance, it must do so without any reference to or assistance from Alabama's HMO statute.

regulated by ERISA, e.g., information disclosure.[6] A state law which allows the award of punitive damages against an ERISA administrator of fiduciary, *even if* the law satisfies the McCarran-Ferguson Act factors, is preempted because Congress intended ERISA's civil enforcement mechanism to be exclusive of other remedies. *Pilot Life; Kanne v. Connecticut General Life Ins. Co.*, 859 F.2d 96 (9th Cir. 1988), *cert denied*, 109 S.Ct. 3216 (1989); *Commercial Life Insurance Company v. Juliano*, 764 P.2d 1059 (Cal. 1988), *cert denied*, 109 S.Ct. 2087 (1989).

While the dicta from *Metropolitan Life Ins. Co. v. Massachusetts* relied upon by Menton and his McCarran-Ferguson Act cases appear to support the proposition that the sale and advertising of insurance by insurance companies is subject to state insurance regulation, Petitioners contend that the following authorities directly support their position that Menton's claim for damages under the twisting provision in the Trade Practices Act is not "saved" from ERISA preemption as a law that "regulates insurance". *Pilot Life; Anschultz v. Connecticut General Life Ins. Co.*, 850 F.2d 1467 (11th Cir. 1988); *Kanne v. Connecticut General Life Ins. Co.*, 859 F.2d 96 (9th Cir. 1988), *cert denied*, 109 S.Ct. 3216 (1989); *Powell v. Chesapeake & Potomac Telephone Co. of Virginia*, 780 F.2d 419 (4th Cir. 1985), *cert denied*, 476 U.S. 1170 (1986); *Keel v. Group Hospitalization Medical Services, Inc.*, 695 F.Supp. 223 (E.D.Va. 1988); *Dennette v. Life of Indiana Insurance Company*, 693 F.Supp. 959 (D.Co. 1988); *Rollo v. Maxi-Care of Louisiana, Inc.*, 695 F.Supp. 245 (E.D.La. 1988). The decision of the Alabama Supreme Court is in conflict with *Pilot Life* and these authorities on the application of ERISA's insurance savings clause.

There is an additional reason why Menton's claims are not "saved" from ERISA preemption by the twisting statute.

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[6] The circuits have held that conduct which "relates to" a plan cannot provide the basis for a claim for punitive damages regardless of whether the claim is denominated in state law or under ERISA. *Amos v. Blue Cross-Blue Shield of Alabama*, 868 F.2d 430, 431 n.2 (11th Cir.), *cert denied*, 110 S.Ct. 158 (1989).

Although Menton pled only a common law fraud claim against the Petitioners, Menton actually tried the case as a "bad faith" claim against an insurance company for the wrongful denial of a claim for benefits.[7] In reality, the verdict and punitive award in this case are based on that portion of Menton's claim dealing with HealthAmerica's denial and refusal to pay his claim. Such claims are undisputedly related to the administration of the claim and are not "saved" from ERISA preemption. *Pilot Life*. The cleverness of counsel in pleading only a one count common law fraud claim but actually trying a bad faith denial of benefits claim should not allow Menton to subvert the intent of Congress.

Finally, Menton is silent as to the recent holding of the Third Circuit in *FMC Corp. v. Holliday*, 885 F.2d 79, 90 (3rd Cir. 1989), that the "deemer" clause requires the preemption of any "state insurance regulation [that] intentionally or unintentionally addresses a core type of ERISA matter which Congress sought to protect by the preemption provision." The

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[7] Petitioners raised, as a separate issue on appeal (VI), the denial of their objections and motion for mistrial based upon the improper argument of Menton's counsel which focused the jury's attention on the fact that HealthAmerica decided to deny Menton's claim for extended rehabilitation benefits even though HealthAmerica was aware that Merle might have given Menton the wrong information and HealthAmerica was aware of the need of Menton's son for rehabilitation ("this child's medical condition"). (RT at 261-264). The trial court denied Petitioners' objections and motion for mistrial which was based on Menton's counsel's deliberate efforts to distract the jury's attention away from the facts pertaining to his fraud claim and onto HealthAmerica's *subsequent* conduct in handling and denying Respondent's claim. The Alabama Supreme Court did not directly address this issue in its opinion. (Pet. App. 20a-21a). An honest and fair review of the record reveals that the excessive punitive award was the direct result of the success of Plaintiff's counsel in focusing the jury's attention on HealthAmerica's conduct in the processing and denial of Menton's claim for benefits and was not the result of Merle's mistake in answering Menton's coverage question. *The jury's verdict was based on HealthAmerica's post-representation conduct and the denial of Menton's claim for extended benefits* – all of which is totally irrelevant to a fraud in the inducement claim.

Court held that, even with regard to "insured" plans, "the deemer clause guards against any insurance regulation that infringes on such ERISA areas as reporting, disclosure and nonforfeitability." *Id.* at 88. Since the application of Alabama's twisting statute in this case directly infringes on the ERISA information disclosure and fiduciary standards regulated by Congress, the deemer clause applies and the twisting statue is not "saved" *even if* it "regulates insurance." This conflict also requires resolution.

III. ERISA'S INFORMATION DISCLOSURE REQUIREMENTS, FIDUCIARY STANDARDS, AND CIVIL ENFORCEMENT SCHEME

Menton argues that the Petitioners failed to raise ERISA's disclosure and fiduciary provisions in the Alabama courts. Menton was the Plaintiff and chose not to claim his ERISA remedies in the trial court. (Pet. App. at 3a). Thus, Petitioners were under no duty to either defend against such claims or to prove Menton's potential ERISA claims. The existence of a federal remedy is not a prerequisite to federal preemption under ERISA. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Lister v. Stark*, 890 F.2d 941, 946 (7th Cir. 1989).

In briefs to the Alabama Supreme Court and at oral argument Menton argued that his claims were not preempted because he would have no remedy under ERISA's civil enforcement scheme.[8] The Petitioners answered this argument, in their Reply Brief and subsequent letter briefs, by pointing out the following: ERISA imposed certain information disclosure requirements on the Press Register as the plan "administrator"; ERISA imposed certain obligations on HealthAmerica as a "fiduciary" under the plan; the disclosure of information to participants about options and coverages is

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[8] The Alabama Supreme Court appears to have adopted Menton's argument that ERISA preemption of state law cannot be applied where there is no federal ERISA remedy. (Pet. App. at 19a). This aspect of the Alabama court's opinion is further grounds for review.

part of the administration of the plan; HealthAmerica may be liable under ERISA for breach of fiduciary duty; the Press Register's failure to satisfy ERISA's disclosure requirements (e.g., making a complete copy of the plan available in the office of the administrator) combined with Merle's incorrect answer might give Menton a claim under 29 U.S.C. § 1132(a) for recovery of the benefit denied, i.e., extended rehabilitation benefits; *et al.* Despite this, the Alabama Supreme Court concluded that Menton had no remedy under ERISA. (Pet. App. 19a).

The record on appeal includes the documents governing the HealthAmerica option within the Press Register's benefit plan and the evidence which establishes that HealthAmerica was an ERISA fiduciary and that the Press Register was the plan "administrator." Petitioners have outlined how Congress regulated the areas of information disclosure and fiduciary responsibilities and provided exclusive enforcement mechanisms. (Pet. 13-17). This court should not refuse to review this case or address these areas because of Menton's failure to plead and prove his ERISA claims in the courts below.

IV. PUNITIVE DAMAGES AND DUE PROCESS

Menton argues that Petitioners' due process challenges to the punitive award were not timely raised. However, the trial court specifically addressed Petitioners' constitutional objections, and Petitioners would direct the Court's attention to the Amici Curiae Brief of the Alabama Defense Lawyers Association, at 7-10, where it is clearly demonstrated that Petitioners' due process challenges are preserved for review.

Menton also argues that Petitioners were provided due process of law under "recently augmented" standards and procedures. However, the authorities relied upon by Menton to support this contention are almost all "post-*Menton*" and were applied by neither the trial court nor the Supreme Court of Alabama to this excessive punitive award.[9] Finally,

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[9] *See Central Alabama Elec. Coop. v. Tapley*, 546 So. 2d 371 (Ala. 1989); *Green Oil v. Hornsby*, 539 So. 2d 218 (Ala. 1989).

Respondent's statement that Petitioners were given "de novo" review of the trial court's damage award is untrue. Such a review (if it exists at all) is one of the "recently augmented" standards and procedures adopted by the Alabama Supreme Court as a response to the constitutional challenges raised in this and other recent cases. It was not applied to this case.

V. FACTS

The Respondent's ("Menton's") Brief In Opposition, contains several incorrect factual assertions. First, Petitioners have carefully reviewed the record on appeal and cannot find any evidence to support the following statement in Menton's Opposition: "Merle also admitted to Mr. Menton that she misrepresented the coverage." (Opp. p.4). Contrary to Menton's assertion, Merle did *not* admit to Menton that she "misrepresented" the coverage. At most, Menton's testimony would support the inference that Merle admitted to Menton that she gave the wrong answer to his question and that she was unaware of the limitation on the duration of such benefits when she answered his question.[10]

"There is no evidence that Ms. Merle was aware of the limitation on physical therapy or rehabilitation benefits when she answered Respondent's question at the meeting." (Petition at p.4). Menton does not challenge this fact in his Opposition. In fact, in his Brief in the Supreme Court of Alabama, Menton

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[10] Menton similarly misconstrued the evidence in the record concerning HealthAmerica's internal investigation of Menton's claim for unlimited rehabilitation benefits: "It was later revealed that Merle had confessed making the misrepresentation during an internal investigation of Mr. Menton's claim." (Opp. p.5). Menton appears to be referring to a "Member Comment Report" on which another HealthAmerica employee wrote that "In follow-up, Pam Merle stated that she had given Mr. Menton the wrong info." (RT 204). What Menton neglected to inform this court is that the person who wrote the above note was not called to testify and the note actually recorded what Menton said he was told by Ms. Merle. (RT 107-209). Merle never "confessed" making any "misrepresentation."

conceded this very point: "As reflected by the evidence in this case, Ms. Merle was *obviously completely unaware* of the sixty day limitation contained in HealthAmerica's plan when she made the representation to Mr. Menton." (Appellee's Brief p.123) (emphasis added). Accordingly, the conduct which caused Menton to switch options (to an "alternative medical benefit selection") within the Press Register's welfare benefit plan was nothing more than a spontaneous answer to a coverage question given without knowledge or notice of a limitation on the duration of rehabilitation benefits.

CONCLUSION

The Petition for Writ of Certiorari should be granted.

Respectfully submitted,

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